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ABSTRACT

The U.S. Advisory Board on Child Abuse and Neglect was established under the Child Abuse Prevention and Treatment Act (CAPTA). In its annual reports, the Board is charged with evaluating the nation's efforts to accomplish the purpose of CAPTA and to propose recommendations about ways those efforts can be improved. Noting that every day, five young children die from abuse or neglect at the hands of their parents or caregivers, this report examines existing efforts and opportunities that aid in understanding and preventing child abuse and neglect fatalities. The report also provides a close look at system-wide weaknesses and obstacles, and lack of resources and commitment by policymakers to take action that could save children's lives. The first chapter of the report explores the lack of knowledge over the scope and nature of child abuse and neglect fatalities, attempting to quantify the problem. Chapter 2 examines the need for better investigation and prosecution and for major efforts to improve and train front-line professionals. Chapter 3 discusses the encouraging emergence of Child Death Review Teams. Chapter 4 examines the need for more aggressive efforts to protect children and to facilitate community-based family services and primary prevention efforts to help families live safe and healthy lives. The report offers 26 recommendations for addressing deep-seated problems within the law enforcement, child protection, health agency, and court branches that constitute the child-protection system. These recommendations include: (1) establishing a national commitment to addressing the problem of abuse and neglect fatalities; (2) increasing the number of professionals qualified to identify and investigate such fatalities; (3) enacting legislation establishing child autopsy protocols; (4) enacting model legislation to address confidentiality; (5) including the religious community in prevention efforts; (6) adopting child safety as the goal of family programs and policy; (7) using family support funding for prevention; and (8) adopting regulatory measures to reduce environmental dangers for children. The report's five appendices include, a list of participants in the board's previous congressional hearings and workshops, a review of child fatalities research and literature, and a sample death certificate. (HTH)

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Administration for Children and Families

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A Nation's Shame: Fatal Child Abuse and Neglect in the United States

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A Report of the U.S. Advisory Board on Child Abuse and Neglect

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Department of Health and Human Services
Administration for Children and Families

A NATION'S SHAME: FATAL CHILD ABUSE AND NEGLECT IN THE UNITED STATES

A Report of the
U.S. Advisory Board on Child Abuse and Neglect

Fifth Report
U.S. Advisory Board on Child Abuse and Neglect
April 1995

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Washington, DC

"A simple child,
That lightly draws its breath,
And feels its life in every limb,
What should it know of death?"

William Wordsworth

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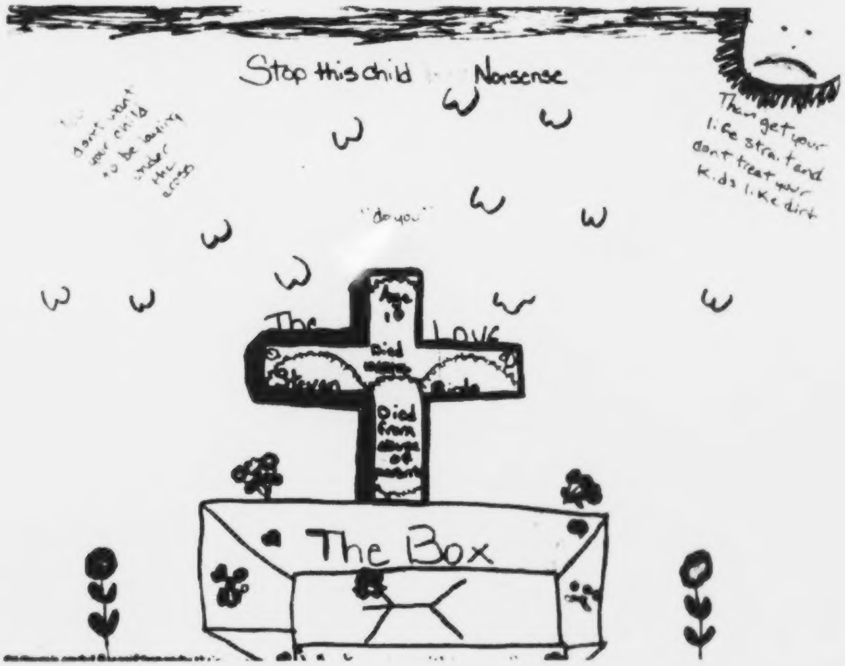
The children's artwork for this report has been provided by ICAN/ICAN Associates, Los Angeles County, from their Child Abuse Prevention Month Poster Art Contest.

DEDICATION

This report is dedicated to the children on the following list and the thousands not named here, who have died at the hands of parents or caretakers. The names are taken from newspaper articles published throughout the country.

Sources: New York Times, Chicago Tribune, Houston Post, Denver Post, San Francisco Chronicle, Los Angeles Times, Boston Globe, Atlanta Constitution-Journal, Philadelphia Inquirer, Miami Herald, Detroit Free Press, Washington Post.


Stop this child Nonsense
don't want your child to be laying under the cross
Then get your life strait and don't treat your kids like dirt
"do you"
The
Love
Age 10
Died
Steven
Died from abuse of
The Box

Joann --6th Grade
Fair Avenue School

Name	*Age*	*Cause of Death*	*Date*	*Location*
Michael A. Lazas, Jr.	*2 years*	*Suffocation.*	*1/93*	*Maryland*
David Welch	*3 years*	*Severely beaten.*	*1/93*	*Florida*
Baby Boy Braz	*2 months*	*Manner unspecified.*	*1/93*	*California*
Franciscò Lopaz	*2-1/2 years*	*Died from 103 body wounds.*	*1993*	*Illinois*
Unnamed	*Newborn*	*Buried alive.*	*2/16/93*	*New York*
Baby Rodriguez	*5 months Twin Girl*	*Severely beaten.*	*2/15/93*	*Texas*
Amy Lynn Mitich	*2 months*	*Suffocation.*	*2/25/93*	*Florida*
Jamiel Neal	*3 years*	*Severely battered and burned with a stun gun.*	*2/28/93*	*Michigan*
Baby Boy Jones	*Infant*	*Manner of death unspecified.*	*2/93*	*Colorado*
Samantha Jo Haight	*4 years*	*Severely beaten.*	*2/93*	*Illinois*
Tommy Eken	*3 months*	*Manner of death unspecified.*	*2/93*	*Illinois*
Ditaya Douglas	*2 years*	*Death by scalding.*	*3/20/93*	*New York*
Shayne Bryant	*4 years*	*Scalded and beaten.*	*3/93*	*New York*
Keeyan Pinnick	*1 year*	*Death by scalding.*	*4/2/93*	*Illinois*
Jose Manuel Garcia	*2 years*	*Burned to death.*	*4/2/93*	*Florida*
Lauren Jandree	*Toddler*	*Severely beaten.*	*4/3/93*	*Texas*
Saraphina Johnson	*5 months*	*Shaken to death.*	*4/93*	*Illinois*
Tiffany Guzman	*1 year*	*Smothered to end crying.*	*4/93*	*Texas*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Brittany Harris	*2 years*	*Manner of death unspecified.*	*4/93*	*Texas*
Devon Phillips	*5 years*	*Stabbed to death.*	*4/93*	*District of Columbia*
Thomas Owenby	*10 months*	*Starved to death.*	*4/93*	*District of Columbia*
Thomas McNeil	*10 months*	*Starved to death.*	*4/93*	*District of Columbia*
Joseph Wallace	*3 years*	*Forcibly hung by neck.*	*4/93*	*Illinois*
Donnell Robinson	*2 years*	*Fatally shaken.*	*5/4/93*	*Virginia*
Tish Phipps	*Toddler*	*Severely beaten.*	*5/8/93*	*Texas*
Ryan Plimpton	*6 months*	*Massive head injuries.*	*5/93*	*Illinois*
Ariel Hill	*5 months*	*Scalded to death.*	*5/12/93*	*Illinois*
Jasmine Kent	*2 years*	*Severely beaten.*	*5/21/93*	*Illinois*
A.J. Schwarz	*10 years*	*Found battered and floating in family pool.*	*5/23/93*	*Florida*
Donnell Shaw	*2 years*	*Massive head injuries.*	*5/26/93*	*Florida*
Brandon Jones	*9 months*	*Massive head injuries.*	*5/93*	*Florida*
Jermey Booze	*2-1/2 years*	*Massive head injuries.*	*5/93*	*Florida*
Robert Earl Jefferson	*2 years*	*Fatally shaken.*	*5/93*	*Florida*
Myowsha Holoman	*1 year*	*Severely beaten.*	*5/93*	*Illinois*
Lindsay Creason	*3 weeks old*	*Smothered to end crying.*	*6/93*	*Colorado*
Adrain Adam Bell	*3 years*	*Severely beaten.*	*7/93*	*District of Columbia*

Name	Age	Cause of Death	Date	Location
Clayton Miracle	3 years	Severely beaten by foster parents.	8/11/93	Georgia
Robert Ward Spencer	8 years	Severely beaten.	9/93	District of Columbia
Cody James	19 months	Forced Valium overdose.	1993	Colorado
Tiarah Bowers	2 years	Chronically battered to death.	7/93	Illinois
Cimantha Shepeard	10 days	Dropped two stories.	7/93	Illinois
Latoya Harris	8 years	Found entombed in cement.	7/93	California
Jeremy Arans	3 months	Massive head injuries.	8/4/93	Illinois
Kevin Kreith	3 years	Severely beaten.	8/93	Illinois
Michael Cecil	2 years	Chronically battered to death.	8/15/93	Illinois
Saleem Broom	1 year	Starved to death.	8/21/93	New York
Denise Rome	2 years	Manner of death unspecified.	9/2/93	Ohio
Louis Murphy	2 years	Severely beaten.	9/17/93	Texas
Anonymous Toddler	3 years	Severely beaten after crying over fear of dark.	9/93	California
Corey Sparks	2 years	Severely beaten.	10/93	Illinois
Brittany Scott	5 years	Massive head injuries.	10/93	Michigan
Jonathan Boylan	6 months	Massive head injuries and choked.	10/13/93	Florida
Kayla Basante	8 months	Choked with blanket.	11/93	Florida
Cecilia Marie Rushing	2 years	Fatally beaten.	11/93	District of Columbia

Name	*Age*	*Cause of Death*	*Date*	*Location*
Tommy Bush	*4 years*	*Severely beaten.*	*11/2/93*	*Florida*
Richard Spells	*4 months*	*Massive head injuries.*	*11/9/93*	*Illinois*
Kieran Dunne	*10 months*	*Severely beaten.*	*11/9/93 or 11/10/93*	*New York*
Tonya Heddins	*2 months*	*Forcibly suffocated following chronic abuse.*	*11/10/93*	*Illinois*
Baby Girl Glover	*5 months*	*Severely beaten.*	*1993*	*Colorado*
Shawna Reeder	*15 months*	*Manner of death unspecified.*	*11/93*	*New York*
Latisha Lawrence	*15 months*	*Manner of death unspecified.*	*11/93*	*New York*
Baby Girl Casares	*Infant*	*Manner of death unspecified.*	*12/3/93*	*California*
Unidentified girl	*17 months*	*Beaten all over body.*	*12/24/93*	*Florida*
Richard Jones	*1-1/2 years*	*Severe intoxication.*	*12/25/93*	*Connecticut*
Michael Marshall III	*Infant*	*Severely beaten.*	*12/93*	*Illinois*
Joseph M. Harvey	*3 years*	*Fatally scalded in bathtub.*	*12/93*	*Maryland*
Christopher Flye	*6 years*	*Severely abused.*	*1993*	*Maryland*
Danny Carter, Jr.	*2 years*	*Severely beaten after bedwetting.*	*1993*	*Virginia*
TeSean J. Bond	*2 months*	*Force fed fatal amounts of Epsom salts and liquid antacids.*	*1994*	*District of Columbia*
Roosevelt Bryan Bell	*5 months*	*Fatally shaken.*	*1/1/94*	*Illinois*
Baby Girl Buchanan	*3 months*	*Starved to death.*	*1/94*	*Illinois*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Baby Williams	*2 years*	*Fatally scalded.*	*1/13/94*	*Texas*
Kelly Jackson	*4 months*	*Fatally shaken.*	*1/20/94*	*Illinois*
Jimmie Williams	*2 years*	*Severely beaten after bedwetting.*	*1994*	*Illinois*
Erick Stark	*16 months*	*Chronically battered.*	*1994*	*Illinois*
Jackie Wright	*7 years*	*Bludgeoned to death.*	*2/94*	*Maryland*
Tenicha Nixon	*8 months*	*Severely battered for crying.*	*3/22/94*	*Florida*
Carol Jean Waters	*Toddler*	*Fatally beaten.*	*3/26/94*	*Florida*
Jasmine Buice	*1-1/2 years*	*Severely beaten.*	*3/9/94*	*Texas*
Jodi Santillo	*3 years*	*Massive head injuries.*	*4/7/94*	*Florida*
Baby girl Wright	*2 years*	*Bitten and severely beaten.*	*4/14/94*	*Florida*
Daryl Bell, Jr.	*2 years*	*Severely beaten after wetting pants.*	*4/94*	*Illinois*
Andre Roberts	*1 year*	*Severely beaten.*	*4/94*	*Illinois*
Tyesha Dixon	*1 year*	*Starved and beaten.*	*4/2/94*	*Texas*
Raychell Ortiz	*4 years*	*Killed and tossed in river.*	*5/4/94*	*New York*
Unidentified	*3 years*	*Beaten with towel rack.*	*5/29/94*	*Florida*
Michael Scott Richman	*1 month*	*Massive head injuries.*	*5/30/94*	*Florida*
Corey D. Taylor	*3 years*	*Pushed into Anacostia River and drowned.*	*5/94*	*District of Columbia*
Charles Sanborn	*10 years*	*Chronically battered.*	*6/94*	*Illinois*
Baby boy Day	*Toddler*	*Manner of death unspecified.*	*6/2/94*	*Florida*
Baby Boy Adams	*14 months*	*Scalded and beaten.*	*6/18/94*	*California*

Name	*Age*	*Cause of Death*	*Date*	*Location*
Anaberta James	*8 months*	*Manner of death unspecified.*	*6/19/94*	*Texas*
Eric Dunphy	*2 years*	*Severely beaten and stuffed into a Christmas ornament box.*	*8/94*	*Rhode Island*
Christina Holt	*7 years*	*Beaten to death.*	*9/94*	*Florida*
Dayton Boyton	*5 months*	*Injuries unspecified.*	*10/94*	*Florida*
Damian Grant	*2 years*	*Fatally beaten.*	*10/21/94*	*Florida*
Sasha Gibbons	*4 years*	*Suffocated.*	*11/23/94*	*Florida*
Unidentified baby girl	*?*	*Head injuries from being tossed in air.*	*12/1/94*	*Florida*
Rafael Jose	*8 years*	*Stabbed in heart.*	*12/10/94*	*Florida*
Anthony Dorch	*1-1/2 months*	*Severely battered.*	*12/13/94*	*Florida*
Tiffany Greenfield	*4 months*	*Fatally shaken.*	*12/21/94*	*Florida*
Joey Fajardo	*3 weeks*	*Fatally shaken.*	*12/24/94*	*Florida*
Baby boy Thorpe	*4 months*	*Found in plastic bag in vacant lot.*	*1/95*	*Florida*
Jonathan Austin	*5 weeks*	*Fatally beaten.*	*1/8/95*	*Pennsylvania*
Felicia Brown	*1-1/2 years*	*Beaten with shoe heel.*	*2/95*	*Michigan*

FOREWORD

by Deanne Tilton Durfee

Chairperson, U.S. Advisory Board on Child Abuse and Neglect

OUR CHALLENGE

The U.S. Advisory Board on Child Abuse and Neglect began the daunting task of confronting the most extreme and tragic consequences of child maltreatment over 2 years ago. This has clearly been the most challenging and the most comprehensive process this Board has yet undertaken. Our study, discussions, review of material, and testimony from multiple States have revealed a problem far greater than previously realized. We also have been the beneficiaries of far greater insight into the strengths and weaknesses of the broader community-and government-based child protection systems.

The cruel realization that parents and caretakers can kill their own children has been difficult for our Nation to face. Indeed, many who make policies, direct programs, and deliver services to children and families have found it difficult to accept. Yet, this is reality.

For so many who question the importance of providing preventive services to high risk families, especially those with small children, let this report serve as a reminder of what the tragic outcome of indifference may be. For those who believe that the child protection system is overly intrusive, let us recall how we might have wished there had been a meaningful intervention before the death of a helpless young victim. Let us also ask how a strong community support system—friends, family, neighbors—could have helped assure the safety of a preschool child who was never seen outside the home until autopsy.

Serving as a member of the U.S. Advisory Board on Child Abuse and Neglect has been a consuming experience. This report, which has required confronting the unnecessary loss of helpless children's lives, has profoundly drawn on the personal and psychological energies of Board members and staff. Yet, by reviewing child deaths, we have been able to expand our appreciation and understanding of the importance of children's lives.

The future work of this Board will benefit greatly from the wealth of information gained through this process. The issues related to child abuse fatalities—accountability, professional qualifications, interagency collaboration, information sharing, and prevention—all sit at the foundation of our entire child protection system.

The Board heard the perspectives of true heroes; professionals, volunteers, and concerned citizens from diverse communities across the Nation. These are some of the most brilliant, dedicated, and insightful individuals we could have the privilege to meet.

We have been motivated by a belief that the purpose of life is to matter, to count, to have it make some difference that we lived at all. Having experienced the pain of children, we seek to honor them and confirm that their brief lives did matter, each and every one of them. By better understanding child abuse and neglect fatalities, and how such tragedies could be prevented, we are given a great opportunity to ensure that it did make a difference that these children lived at all.

ACKNOWLEDGMENTS

The Board members, staff, and others involved in the development of this report have invested their hearts, minds, time, and energy to making a difference in the lives of children and families in America.

It has been a profound honor to serve as Chair of this prestigious Board for the past 2 years. I came into this position following in the footsteps of two of the most highly respected professionals in this field, **Richard Krugman** and **Howard Davidson**, our Board's first two Chairs. We all owe much to their leadership and the standards and direction they set for our work. Other previous members of the Board who participated in the initial stages of the development of this report also deserve recognition. They should feel justifiable credit for their role in laying the groundwork for this report.

Special recognition must be given to the Vice-Chair of the Board **Yvonne Chase**, who provided direction, advice, and leadership in all aspects of the Board's work. She also provided me with invaluable personal support. During the process of developing this report on child maltreatment fatalities, Yvonne took leadership in organizing meetings, symposia, and hearings on cultural diversity in partnership with the People of Color Leadership Institute (POCLI). These forums produced unique and enlightening dialogue and constitute an important foundation for future Board reports.

All members of the Board deserve credit for their dedication to protecting children and serving families and for their important contributions to this report. Special recognition was earned by the members of the Board's Executive Committee, **Randy Alexander, Jane Burnley, J. Tom Morgan, and Michael Weber,** for their additional investment of time and energy. This included frequent conference calls, special meetings, repeated editing, and responsibility for developing sections of the draft report. **Enid Borden,** former member of the Executive Committee, continued to share her considerable creativity with the written word, and **Murray Levine** brought us a wealth of talent in research and evaluation.

The Executive Director of the Board, **Preston Bruce,** has been our ambassador, our source of moral support, and one of the kindest and most caring individuals I have had the pleasure to know. Preston brings a strong heritage of distinguished public service to his work. Sadly, Preston's father passed away only a few months before this report could be completed. There is no doubt he would have been very proud of his son.

Our Board met with tremendous good fortune when we contracted with **Laurel Consulting Group,** a professional management services firm that exceeded all of our expectations for both quality and quantity of work. We owe special thanks to **Conrad Kenley**, President of LCG, whose mind and management skills are unparalleled, and to **Anne Marie Finn,** policy analyst, whose intelligence, good nature, and ability to absorb and translate masses of information proved invaluable. Conrad and Anne Marie, joined by other outstanding LCG staff, worked into nights and weekends to assure that this report was of high quality and completed on time.

Jill Stewart a widely respected newspaper and magazine writer, provided our Board with the gift of her notable journalistic talent. She was the individual who brought together the masses of information presented to us from testimony;local State and Federal reports; journal articles, news reports and literally thousands of pages of transcripts from hearings, symposia and meetings. Her organization, creative mind, writing skills, and a deep personal concern for the children about whom she was writing made her an invaluable member of our "team."

Penny Weiss, ICAN Assistant Director, and **Mitch Mason,** ICAN Program Analyst, deserve a great deal of credit for lending their considerable talents to many aspects of this report, and for their patience with me during my term as Chairperson.

Finally, I most sincerely thank **Michael Durfee,** my hero and best friend. He has provided me with unrelenting encouragement and moral support, even when I have found myself tired and rather intolerable. Moreover, he is more responsible than anyone I know for moving this country toward a better system of accountability for the serious and fatal abuse of children.

The Board also wishes to acknowledge the important contributions of the following individuals and organizations in the development of this report:

- Jose Alfaro, Director of Research, Children's Aid Society and Donya Witherspoon, Attorney at Law for lending their expertise to the task of summarizing expert testimony taken by the Board in New York City and Los Angeles.

- Sharon Smolick Director of Family Violence Program, Bedford Hills Correctional Facility for her cooperation in allowing Board members access to the women who shared their stories with us.

- Cheryl Compaan and Jennifer Freeman at the State University of New York for additional bibliographic research.

- All of the Department of Health and Human Services Regional staff for their logistical support and input in public hearings and forums.

- and, finally, the Board would like to thank Cathie O'Donnell from Circle Solutions Inc. for editing this report.

MISSION AND COMPOSITION OF THE U.S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

The U.S. Advisory Board on Child Abuse and Neglect was established under 100-294, Section 102, of the Child Abuse Prevention and Treatment Act (CAPTA), amendments of 1988. It consists of 15 members appointed by the Secretary of Health and Human Services (DHHS). Members represent a wide range of legislatively mandated disciplines, as well as various regions of the country and diverse personal perspectives. The name, title, and address of each Board member are listed in Appendix A.

Explicit provisions of CAPTA require the Board to prepare an annual report to the Secretary of DHHS, appropriate committees of Congress, and the Director of the National Center on Child Abuse and Neglect (NCCAN). In its reports, the Board is charged with evaluating the Nation's efforts to accomplish the purpose of CAPTA and to propose recommendations about ways those efforts can be improved.

In its first report in 1990, the Board concluded that the problem of child maltreatment in the United States had escalated to the level of a national emergency based on the alarming increase in the number of abuse and neglect reports and the negative consequences for society, especially for children. It recommended 31 critical steps to address this national emergency, directed to all levels of government, all professional disciplines and each citizen. One recommendation called for an effort to bring agencies together at local, State, and Federal levels to address fatal child abuse and neglect.

In its second report in 1991, the Board urged funding, structural reforms, and action at the Federal level to bring critically needed preventive services to communities. Key among its recommendations was the implementation of universal voluntary neonatal home visiting programs as a means of early prevention of abuse and neglect. The third report, in 1992, was devoted largely to recording Board activities and positions issued that year.

Building on the community-based preventive philosophy of its 1991 report, in 1993 the Board described the steps that must be taken to create a comprehensive new neighborhood-based prevention strategy in which government, front-line professionals, neighbors, families, and friends all play a role.

This report reflects a response to the Board's longstanding concern for children who die at the hands of their parents or caretakers. Members of Congress shared this concern, and in 1992 congressional hearings were held, resulting in a mandate to the Board to issue a report on the nature and extent of child abuse and neglect fatalities and how these tragic deaths might be prevented.

EXECUTIVE SUMMARY

Background

In 1991, a riveting PBS documentary told the story of the brutal death of malnourished 5- year-old-Adam Mann, beaten to death on March 3, 1990, by his stepfather, Rufus Chisolm, with participation by his mother, Michelle Mann (Langer, 1991). Many professionals had missed a series of red flags that Adam was in serious danger. The autopsy of Adam revealed over 100 injuries on his body. Following the autopsy, the cause of death was listed as a broken skull, broken ribs, and a split liver. At one time or another, nearly every bone in his body had been broken. In addition, there was no food in his stomach. Adam's stepfather and mother were imprisoned and Adam's siblings were placed in foster care. The story of this child's death, as well as compelling testimony regarding hundreds of child abuse fatalities, prompted Congress to ask the U.S. Advisory Board on Child Abuse and Neglect (ABCAN) to recommend:

2,000 children die from abuse or neglect each year...or 5 children every day.

- a national policy to reduce and ultimately prevent such fatalities,
- changes to achieve an effective Federal role on the implementation of the policy, and
- changes needed to improve data collection about child abuse and neglect fatalities.

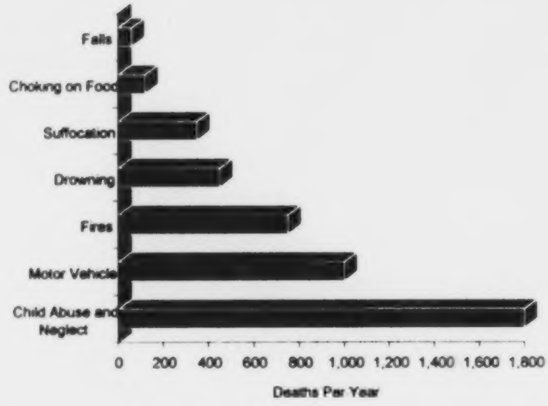
Since Adam's death, some 10,000 children have died at the hands of their parents or caretakers.

Conservative estimates indicate that almost 2,000 infants and young children die from abuse or neglect by parents or caretakers each year, or *5 children every day.* The vast majority are under 4 years old,

Homicide rates among children age 4 and under have hit a 40-year high.

an age when they are most vulnerable to physical attacks and to dangers created by lack of supervision and severe neglect, and are isolated from teachers or others who might intervene to protect them. According to the Population Reference Bureau, death rates among children age 4 and under who die from homicide have hit a 40-year high (Mackellar & Yanagishita, 1995; *Baltimore Sun*, 1995). Violence towards very young children has reached the level of a public health crisis and is similar in scope to the destruction of teenagers by street gunfire.

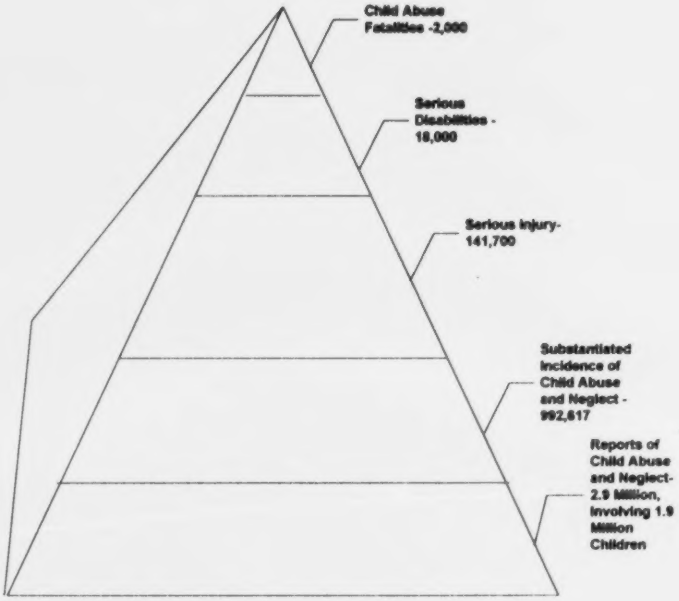
Leading Causes of Trauma Death Age Four and Under



Source National Safety Council Child Abuse and Neglect deaths from Centers for Disease Control and Prevention

Yet the American public, as well as many government leaders and policymakers at the local, State, and Federal levels continue to regard these deaths as if they are rare and tragic curiosities. We hope to dispel this notion, which we believe impedes any meaningful solution. McClain's research at the Centers for Disease Control and

Prevention (CDC) suggests that abuse and neglect kills 5.4 out of every 100,000 children age 4 and under (McClain et al, 1993; McClain, 1995). However, due to the misclassification of child deaths, McClain believes that a second conservative estimate can be as high as 11.6 per 100,000 children age 4 and under (McClain, 1995). This is a shocking rate compared with deaths among teenagers from gunshot wounds and deaths among children age 15 and under from auto accidents—neither of which are downplayed as "rare" events. As shown, abuse and neglect has become one of the biggest threats to the lives of infants and small children in America. Deaths from abuse and neglect of children age 4 and under outnumber those from falls, choking on food, suffocation, drowning, residential fires, and motor vehicle accidents.


Child Abuse Fatalities -2,000
Serious Disabilities - 18,000
Serious Injury- 141,700
Substantiated Incidence of Child Abuse and Neglect - 992,617
Reports of Child Abuse and Neglect- 2.9 Million, Involving 1.9 Million Children

Sources: U.S. Advisory Board on Child Abuse and Neglect; Baladerian, Verbal testimony, 1994; NCCAN, 1991; National Committee to Prevent Child Abuse

It is particularly difficult to accept the alarming levels of abuse and neglect deaths in the 1990's, given that death rates among infants and young children from all other major causes are steadily declining.

Yet fatalities are not the entire story. The misery caused by near-fatal abuse and neglect ripples through this country, each year leaving 18,000 permanently disabled children (Baladerian, 1991), tens of thousands of victims overwhelmed by lifelong psychological trauma, thousands of traumatized siblings and family members, and thousands of near-death survivors who, as adults, continue to bear the

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physical and psychological scars. Some may turn to crime or domestic violence or become abusers themselves.

...141,700 infants and children were seriously injured due to abuse or neglect in 1990 alone.

Near-fatal injury is nearly as appalling in its destruction as the toll of dead children. Many children with head injuries known to be caused by abusive caretakers are left with lifelong cerebral palsy (Diamond & Jaudes, 1983). The National Center on Child Abuse and Neglect (NCCAN) estimates that 141,700 infants and children were seriously injured due to abuse or neglect in 1990 alone (1991). The National Research Council (NRC) points out that, beyond these human costs, "the future lost productivity of severely abused children is $658 million to $1.3. billion, if their impairments limit their potential earnings by only five to ten percent" (NRC, 1993, p. 40).

Each year we learn more about which children have died and which parents and caretakers are responsible. We know that a disproportionate number of victims come from low-income families with multiple problems. However, children of middle-and-high income families also die at the hands of their parents or caretakers. Such was the case of Lisa Steinberg who died in 1987 under the care of Joel Steinberg and Hedda Nussbaum, an upper middle-class white couple. In addition, research suggests that males cause most physical abuse fatalities, and that mothers are held responsible for most deaths caused by severe neglect. Furthermore, abuse and neglect deaths are not limited to inner cities. Such deaths occur in many communities, including isolated rural areas.

What we must ask is why. Must 2,000 babies and small children die at the hands of their parents or caretakers in 1995? What events lead up to these tragic deaths? What goes on in the minds of parents or caretakers that cause them to abandon their protective roles and lash out at or severely neglect tiny, helpless children? Angry

Americans asked this question of Rufus Chisolm and Michelle Mann, as well as Joel Steinberg, who beat their children to death. But these are questions that cannot be answered—or addressed—until this Nation chooses to tackle this long-ignored crisis in a meaningful way.

How Can We Address This Devastating Crisis?

This report offers a discussion of the existing efforts and opportunities that show promise in helping us to understand and prevent child abuse and neglect fatalities. These efforts emerge from motivated individuals and agencies that have assumed strong leadership roles in the response to and prevention of child abuse and neglect fatalities. In addition, many communities have established neighborhood support systems to prevent child abuse and neglect.

This report also provides a close look at systemwide weaknesses and obstacles, and a lack of resources and commitment by policymakers to take action that could save children's lives. Thus, we wish to send a wake-up call to those who may minimize this crisis and to those who do not know this crisis exists.

We offer 26 Recommendations for addressing deep-seated problems within the law enforcement, child protection and health agencies and courts that comprise the country's child protection system. Our Recommendations are addressed to Congress, States, public policymakers, and all citizens.

The four chapters of the report address: (1.) the lack of knowledge over the scope and nature of child abuse and neglect fatalities, (2.) the need for better investigation and prosecution and for major efforts to improve and train front-line professionals, (3.) the encouraging emergence of Child Death Review Teams, (4.) the need for more aggressive efforts to protect children and facilitate community-based family services and primary prevention efforts to help families live safe and healthy lives.

Chapter One: Quantifying the Problem

Our society has, in this century, kept a watchful eye on virtually every cause of child death, using what we have learned to quantify the scope and nature of threats to children's health and safety and then to design prevention efforts. These efforts have included the war on polio and, more recently, the massive investment in automobile safety seats for children younger than age 4. But when it comes to deaths of infants and small children due to physical abuse or severe neglect, few resources have been expended to understand this phenomenon. Its scope and very nature remain essentially unknown.

...85 percent of childhood deaths from abuse and neglect are systematically misidentified.

It has been estimated that 85 percent of childhood deaths from abuse and neglect are systematically misidentified as accidental, disease related, or due to other causes (NRC, 1993; McClain et al, 1993; Ewigman et al, 1993). This arises from poor medical diagnoses, incomplete investigations, and widespread flaws in the way deaths are recorded on death certificates, in crime reports, and by the child protection system.

As a result of this misclassification and misdiagnosis, we do not have a reliable source to determine accurately why or exactly how many children die from abuse and neglect. Each national information system is incomplete as a source of comprehensive information on child abuse and neglect deaths. Vital Statistics, the FBI's Uniform Crime Reports, and State child abuse indices each track just one limited part of the picture.

> *"The germ theory of disease is at least a century old, and I often say that we're at about the year 1930 in terms of our understanding of child maltreatment. We are still arguing about whether a case is maltreatment or not, just as we once argued, is this an infectious disease or not?—Dr. Bernard Ewigman, University of Missouri, Department of Medicine, New York Focus groups, 1994*

In Chapter One, our Recommendations address this widespread lack of knowledge that badly hampers our ability to prevent fatal child abuse and neglect. Significantly reducing fatal child abuse and neglect and the attendant broad social, economic, and personal costs of severe abuse and neglect among survivors requires the highest level of attention, a far more sophisticated understanding of the problem, and a much greater commitment of our resources.

Chapter Two: Government and Individual Responsibility

The systems created in the United States to ensure that adult homicides are thoroughly investigated were never developed for children who die due to abuse and neglect by parents or caretakers. In times past, children were often seen as property. Many police, prosecutors, and judges viewed such deaths as a strictly social problem, not a criminal issue. Today, systemic failures created by those attitudes linger on. The question of who harmed a child is often never asked or answered, and in too many cases perpetrators have gone undetected to harm or kill other children.

Even if a fatality is recognized by the system and an investigation is launched, the criminal justice system may respond poorly. Prosecutors often reduce child homicides, including those of a heinous nature, to lesser crimes or do not charge perpetrators at all. Prosecutors are hampered in part by murder statutes that do not fit many child fatalities. Cases are difficult to prove in court because most prosecutors have little training in child abuse and neglect, insufficient evidence is gathered, and autopsies are rarely performed by medical examiners with sufficient pediatric expertise. These problems in prosecuting cases are exacerbated by the fact that

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witnesses are rare because most deaths occur in the privacy of the home, and some jury members cannot believe that any parent or caretaker would commit such acts upon a child.

Many of the key agencies involved still do not fully exercise their roles in investigating abuse and neglect or in assuring a child's safety. For example, a coroner may label a case of inflicted suffocation as "Sudden Infant Death Syndrome" to protect a family's reputation. The breakdown can be seen in the numbers of mandated reporters who do not alert child protective service (CPS) agencies when they recognize a child as abused or neglected. Zellman & Anther (1990) found that 22 percent of mandated reporters, including pediatricians, school principals, therapists, and day care operators, do not report suspected cases of abuse. They cited a lack of hard evidence of abuse and neglect—which is not required to make a report—and their belief that "I can do better than the system." They are often breaking State law.

Such practices among those who could be saving children's lives are extremely significant when one considers how many children die before their families are reported to a CPS agency. Over half the children who die from abuse and neglect nationwide are from families who have never been investigated by CPS. Yet, thousands of children who died in the past decade were known to at least one professional or agency that might have intervened to save their lives.

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The lack of specialized training among those who deal with high-risk families is the single biggest impediment to improving the system in two critical areas: saving children by recognizing life-threatening abuse or neglect and establishing how and why a child has died. It is clear that most police, medical examiners, health practitioners, and CPS workers do not have the level of expertise needed to protect children from serious child abuse and neglect. We believe a concerted new training effort is needed.

States have struggled to address problems within the judicial system, noncompliance by mandated reporters, and systemwide training inadequacies. In the face of such basic, deep-rooted problems, it is not hard to see why the system appears to be in disarray when yet another tragic death of a child is made public in the media. We believe it is time for physicians, hospitals, police, prosecutors, teachers, therapists, the clergy, and communities at large to become active participants in a comprehensive child protection system and to bear greater responsibility for the safety of children.

In Chapter Two, our Recommendations further our philosophy of better educating professionals to identify and investigate abuse and neglect and to hold perpetrators responsible for child deaths.

Chapter Three: The Need For Child Death Review Teams

Our understanding of fatal child abuse and neglect is hampered by a vast societal lack of awareness combined with avoidance of the issue. In the 33 years since Dr. C. Henry Kempe first described the Battered Child Syndrome, more children have died from child abuse and neglect than from urban gang wars, AIDS, polio, or measles; yet the contrast in public attention and commitment of resources is vast.

An encouraging new development is the emergence of multiagency/multidisciplinary Child Death Review Teams, a phenomenon still so new and evolving that the very existence of the teams is not yet widely known to the public or national media. Already, Child Death Review Teams have become one of our richest sources for understanding this quiet crisis. On a regular basis, teams must grapple with systemwide flaws and outmoded policies that often work to prevent authorities from recognizing and properly responding to deaths due to abuse and neglect. Experts from multiple agencies and disciplines serve as members of the teams. These teams review cases of child deaths and facilitate appropriate follow up. Such followup includes assuring that services are provided to surviving family members, providing information to assist in the prosecution of perpetrators, and developing recommendations to improve child protection and community support systems. In addition, teams can assist in identifying weaknesses in the child protection system and determining avenues for prevention efforts and improved training of front-line workers.

State-level teams may review individual cases, or in larger States, provide support and accountability for local teams. Well-designed, properly organized Child Death Review Teams appear to offer the greatest hope of defining the underlying nature and scope of fatalities due to child abuse and neglect.

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In Chapter Three, our Recommendations emphasize the critical importance of Child Death Review Teams in assessing child fatalities, pinpointing system flaws, and promoting prevention services. Diverting even a small fraction of our national attention and resources to an integrated and comprehensive approach to the defense of children's lives is a monumental task that should begin with the broad use of Child Death Review Teams.

Chapter Four: Toward a Better Future

Part One: Family Services, Intervention, and Family Preservation

Child welfare and law enforcement agencies have an explicit statutory mandate to intervene to protect children when the family does not provide that protection. However, if the system is going to save children, this responsibility must be greatly broadened and seen as a collaboration among law enforcement, social service, public health, and education systems. The final critical component to this broader system must be neighbors, extended family, friends, and local agencies in every community. The child's safety and well-being must be a priority in all child and family programs.

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Unfortunately, in many States, laws and policies regarding child protection and case management are inadequate or conflicting. The roles of all child protection agencies, especially with regard to emergency measures and followup investigations with parents, may be poorly defined. Moreover, most citizens do not feel a sense of responsibility for protecting the children in their neighborhoods.

Hundreds of thousands of families in which child abuse or neglect is confirmed do not even receive basic services to ameliorate the negative effects of such maltreatment (McCurdy & Daro, 1992). The cases are merely monitored and closed. In addition, decisions by front-line workers are often not responsive to a family's needs. These decisions are affected by limited funds and restrictive eligibility requirements.

The recent legislation creating the 5-year, $1 billion Family Preservation and Family Support Program has given States and counties a tremendous opportunity to shift from this crisis-driven response system toward one that reduces the core family problems that we believe lead to abuse and neglect fatalities.

It is the strong belief of this Board that this legislation should serve as a catalyst for the growth of an integrated, prevention-oriented, community-based system of support for families and children.

Part Two: Fatality Prevention

There is probably no greater area of public debate in the child welfare field than the issue of how society should prevent fatalities at the hands of parents and caretakers. Invariably, when the death of a small child is reported in the media, well-meaning journalists and policymakers blame the CPS worker who appeared to know a child was living under dangerous conditions and yet failed to rescue that child.

We, as a society, want swift action and clear-cut policies. We condemn what appears to be the failure of the system and the "passing of the buck." However, this Board is convinced that the public debate over who "made a mistake" that led to a child's death focuses on the wrong issues. The best chance we have for reducing these deaths is by beginning to ask the right questions and focusing on the right issues. The media can play a key role in sending accurate and influential messages that could reduce serious and fatal child abuse and neglect not only to parents, but to all citizens.

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The truth is that, except in obvious cases of imminent danger, no single agency or individual in the multiagency system of child protection workers, police, physicians, and courts has the ability to foresee serious abuse or neglect that can cause a child's death. In many ways, we are as ignorant about abuse and neglect fatalities today as we were about child sexual abuse in the 1970's. Many thousands of infants and small children today live in what the literature refers to as "high-risk" families. In 1993, 500,00 to 650,000 parents and children were living in the streets either temporarily or permanently (personal communication, Debbie Chang, National Alliance to End Homelessness); 3.3 to 10 million households with children contained a violent male with a history of domestic abuse (Schecter & Edleson, 1994); and 11 million parents with children were abusing drugs and alcohol (personal communication, Narconon, U.S. Drug Education Division). Each of these factors is considered a risk factor for child abuse and neglect.

The minimal research conducted in this area has not identified specific behaviors that can single out parents whose action or inaction might end a child's life. Currently, the best predictor of future abuse is a pattern of past abuse.

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This Board is urging Congress, the States, and policymakers to greatly improve the existing primary prevention efforts. In providing a comprehensive, early safety net for all children, we hope to influence the lives of many families, and thus identify and protect those unknown innocents who need our help the most.

Our design for primary prevention stresses child and family well-being in a healthier, more active, community-based setting. We are building upon our 1991 and 1993 Board reports, which urged the creation of a neighborhood-based, community system to serve families and the inclusion of neighbors, family, and friends in assuring the safety and well-being of children. This should include informal family and neighborhood support, assistance with difficult parenting issues via community-based programs, and crisis intervention services. It is our belief that, given such support, more parents and caretakers will welcome a helping hand when it is needed and will raise their children in safety.

However, this Board also recognizes that some parents and caretakers, even with supportive services, cannot provide a safe home environment for their children. Therefore, it is imperative that, when necessary, a child's safety and well-being must be protected through prompt removal from the home and by expedited termination of parental rights (TPR) actions by the juvenile courts. We strongly believe that any child who suffers abuse or lives in a severely abusive family deserves permanent placement with a family who is willing to nurture and care for that child.

In Chapter Four, we pinpoint the populations at greatest risk for becoming victims of fatal abuse and neglect—very young children—as well as those at greatest risk for becoming perpetrators—male caretakers and parents of toddlers and infants. This Board emphasizes the great need for public awareness campaigns. In addition, we urge that when a family completely fails a child, the child be given a second chance with a new life and a new family in an expeditious manner.

Conclusion: The Challenge

ABCAN hopes that this report will awaken America to the national shame of child maltreatment-related fatalities and will galvanize all Americans to act now to prevent these tragedies.

SUMMARIZED RECOMMENDATIONS
OF THE
U. S. ADVISORY BOARD ON CHILD ABUSE AND NEGLECT

Recommendation 1: Our Nation must establish a national commitment at the highest levels to understand the scope and nature of fatal child abuse and neglect.

We urge the U.S. Attorney General and the Secretary of Health and Human Services to devote existing resources and expertise to address the lack of knowledge regarding the true nature and extent of fatal child abuse and neglect in America.

Recommendation 2: Federal and State agencies must significantly increase research efforts on serious and fatal child abuse and neglect.

Research is needed to address the serious gaps in information on issues such as the effects of poverty, race, domestic violence, and substance abuse in serious and fatal child abuse and neglect, as well as the effectiveness of current services in preventing serious and fatal injury.

Recommendation 3: The supply of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.

The leadership of the Department of Health and Human Services and the Department of Justice should work with professional associations to develop a national strategy to address the dramatic lack of medical, law enforcement, legal and social service professionals qualified to identify and investigate child abuse and neglect fatalities.

Recommendation 4: There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of serious and fatal child abuse and neglect.

The Secretary of Health and Human Services and the U.S. Attorney General should utilize funds to improve multidisciplinary training in all disciplines charged with identifying and investigating child abuse and neglect fatalities, with an emphasis on crosstraining where possible. This effort should be tailored to a broad audience including child welfare workers, law enforcement officers, prosecutors, mental health practitioners, physicians, paramedics, emergency medical technicians, and others who might work in a front-line capacity.

Recommendation 5: States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

All States should create criminal investigation teams either at the local or regional level to investigate any "unexpected child death." Each team should include, at a minimum, a medical examiner, law enforcement officer, CPS worker and prosecutor. These teams should investigate all unexpected child deaths. Military branches and Indian Nations should work with Federal and State law enforcement and health authorities to establish such teams.

Recommendation 6: States and the Joint Commission on Accreditation of Health Care Organizations should adopt requirements to assure that all hospitals with pediatric services have Suspected Child Abuse and Neglect (SCAN) teams.

Any hospital with a pediatric unit should be required by the State, military branch, or Indian Nation, which oversees its certification, to have a SCAN team. SCAN teams should include a physician, social worker, and nurse specially trained to recognize, treat, report, and consult on suspected child abuse and neglect cases.

Recommendation 7: All states should enact legislation establishing child autopsy protocols. Federal funding for autopsies of children who die unexpectedly should be available under Medicaid.

Autopsies should be required at a minimum when any child's death is suspected as being a homicide or suicide, the child was not under supervision of medical personnel at time of death, or the cause of death is not readily determinable.

Recommendation 8: States should take steps to ensure that all children have access to available, necessary medical care when they are at risk of serious injury or death.

All states should ensure that child abuse laws include the provision that parents must provide medical care when such care is available and necessary to protect the child from death or serious harm. Failure to do so is reportable under child abuse and neglect reporting law.

States should ensure that all health care providers, including spiritual healers who receive healthcare reimbursement, are listed as mandatory reporters of child abuse and neglect, thereby involving such providers in training activities that are conducted for mandatory reporters.

Recommendation 9: States should enact "felony murder or homicide by child abuse" statutes for child abuse and neglect. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies.

Felony murder or homicide by child abuse and neglect statutes in all States should specifically include child abuse or neglect as one of the underlying felonies, as currently is the case in 21 States.

Recommendation 10: The Secretary of Health and Human Services and the U. S. Attorney General should work together to assure there is an ongoing national focus on fatal child abuse and neglect and to oversee an ongoing process to support the national system of local, State, and Federal child abuse and neglect fatality review efforts.

A national structure is needed to incorporate the knowledge of the teams, establish a mechanism for disseminating that knowledge, and facilitate development of a national perspective to prevent child abuse and neglect fatalities. This can be accomplished through the designation of individuals within the Department of Health and Human Services and the Department of Justice who would assume ongoing responsibility to support the process and the semi-annual convening of experts from throughout the country to review and analyze relevant data, share information, track national trends, and develop recommendations.

Recommendation 11: A national-level effort should ensure that services and training materials on fatal child abuse and neglect are made available to all states.

Federal resources must be allocated to provide a far more meaningful level of expertise, technical assistance, and resources to professionals and agencies who need it. The Secretary of Health and Human Services and the Attorney General should oversee this interdisciplinary effort.

Recommendation 12: All States should have State level Child Death Review Teams. Such teams should also be established within the military branches, Indian Nations and territories,

These multidisciplinary/multiagency child death review teams should include participation from criminal justice, health, social services, and other relevant agencies and individuals. The teams should provide support to local teams and publish an annual report that summarizes local case findings and provides recommendations for systemwide improvement in services to prevent fatal abuse and neglect.

Recommendation 13: Child Death Review Teams should be established at the local or regional level within states.

Local multidisciplinary/multiagency teams are the core of the child death review system. They conduct individual case review, assist with case management, and suggest followup and systems improvements. Regional teams may be effective in multicounty rural areas or in areas that border other nations. Such regional teams are also effective in key population centers and regions where counties may benefit from sharing information and statistics.

Recommendation 14: Model legislation should be enacted to address confidentiality.

Information sharing is critical to the effective functioning of Child Death Review Teams. Federal regulations should assure immunity from legal sanctions for agencies and team members who share information in the course of the team's work and protect such information from judicial discovery. States should enact legislation to clarify their ability to share information among law enforcement, CPS, mental health, and health agencies.

Recommendation 15: States and communities should assure that the religious community is included in efforts to prevent child abuse and neglect fatalities.

The religious community should be an active participant in State and local efforts to prevent serious and fatal child abuse and neglect. Members of the clergy should also be recognized as a vital resource in the provision of personal support, spiritual guidance, and counseling to surviving siblings and other family members who survive fatal child abuse and neglect.

Recommendation 16: All child and family programs must adopt child safety as a major priority.

Family, child welfare, health, mental health, and education programs must adopt children's safety as a major priority and explicitly assess the child's safety while providing services. Goals must also include the child's overall well-being and development and the preservation of the family.

Recommendation 17: All relevant State and Federal legislation must explicitly identify child safety as a goal.

Congress and State legislatures must explicitly identify child safety as a major goal. This goal must be statutorily presented as consistent with other public policy goals, such as family preservation and permanence for children.

Recommendation 18: The decision to remove children from their homes or initiate family preservation services should be made by a team.

Child protection and law enforcement agencies should use multidisciplinary team assessment and decision making whenever possible.

Recommendation 19: Family preservation services should be available in every jurisdiction.

Intensive family preservation services should be available in every jurisdiction as an option.

Recommendation 20: States should use guidelines when considering family preservation services.

Until the completion of needed research on the families most likely to be helped by family preservation services, States should use guidelines focusing on the safety and well-being of children in determining whether such services are the appropriate option for a specific family.

Recommendation 21: An array of primary prevention services and supports, including home visiting, must be made available to all families.

Primary prevention means helping families before an incident of abuse or neglect occurs. Because it is impossible to predict which families will kill their children, the most effective prevention is to support parents in being effective and nurturing, to provide treatment services when family problems do arise, and to respond quickly and appropriately when abuse or neglect is identified.

Recommendation 22: Family support services funding should be used for prevention programs aimed at families with infants and toddlers.

Because most children die from abuse or neglect before age 4, available Family Support funds and other prevention funds should be used to significantly increase the emphasis on mothers, fathers, and other caretakers of infants, toddlers, and preschoolers.

Recommendation 23: State and local agencies should design prevention programs for men. Programs should integrate services on child abuse and domestic violence and address the need for interagency training.

Specific strategies must reach men and alert women to the potential role of men in abuse. These strategies should be funded via Federal Family Preservation and Support monies, as well as public and private sources at the state and local levels. Because of the correlation and frequent coexistence of domestic violence and child abuse, programs must address all forms of family violence, especially when children are in the home.

Recommendation 24: Expedited TPR should be developed in every State.

When voluntary TPR is not an option, CPS agencies, States, and the juvenile courts should develop ways to expedite court TPR and placement with a permanent family in situations when a child cannot safely remain with or return to parental custody.

Recommendation 25: A broad public prevention campaign should be developed to address serious and fatal child abuse and neglect.

Well constructed campaigns can help educate parents about the triggers associated with serious injury and deaths of infants and children and suggest alternative means to cope with such problems. Such campaigns can also substantially increase public awareness about how to report abuse and how to prevent harm to children. The media should play a major role in this effort because of its unique ability to reach into homes of millions of people, including those who need help and those who might help others.

Recommendation 26: Regulatory measures should be adopted to reduce environmental dangers.

Regulations and codes should be enacted to end preventable child fatalities and serious injuries from household hazards and environmental dangers.

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PREFACE

We have all seen the stories in the newspapers and on the evening news. A mother kills her children. A teenager, babysitting for young nieces and nephews, gets angry and throws a child against a wall. A father who cannot handle a child's crying lashes out with his fists in frustration.

While it seems that society should feel its greatest sense of shame when a child dies from abuse or neglect, instead our overwhelming reactions are outrage, shock, disbelief, and sometimes denial. Because most of us do not understand how a parent or caretaker could bring him or herself to kill a child, we feel paralyzed and powerless to prevent future deaths. The U.S. Advisory Board on Child Abuse and Neglect (ABCAN) believes that in order to change this situation, Americans need to hear the truth about fatal child abuse and neglect.

Americans need to hear about tens of thousands of children hurt or killed by their parents or caretakers each year. They need to hear about parents who know too little about child rearing and about households that exist in an atmosphere of stress and isolation. They need to hear about a child protection system able to provide only minimal attention or support to parents until after abuse occurs. They need to hear about a system that places too little emphasis on acting to save a child before he or she is irreparably harmed and that places too much emphasis on intervening after a crisis has reached a tragic peak. In short, they need to hear about devastating tragedies that could and must be prevented.

ABCAN believes that fatal child maltreatment is not one of life's deadly inevitabilities. Nor is it just one of a long litany of social problems taking its place in line behind many others. It is an crisis that needs to be treated with the seriousness of any major health threat.

The incidence of fatal child abuse is greater than most of us realize. Last year some 2,000 children died in America at the hands of their parents or caretakers. Some approximate that more than 18,000 children suffered permanent disabilities from abuse or neglect while 141,700 sustained serious or near-fatal injuries. Yet these estimates probably underrepresent the true extent of the problem. Until we develop more comprehensive and sophisticated data, our efforts to understand and prevent child maltreatment-related deaths will be severely handicapped. With an improved understanding of the magnitude of fatal abuse and neglect, it will become possible to better understand this tragedy and take steps that will keep children who are at risk of abuse from becoming the subject of newspaper headlines.

ABCAN has conducted a 2-year study on child abuse related fatalities, traveling to 10 States to hear the public and experts in many professions provide information on this phenomenon. One of the most instructive events was the Board's visit to the Bedford Hills Correctional Facility in New York where we heard disturbing testimony from women incarcerated for abusing or killing their children. From them we learned important lessons about the pain and abuse they suffered as children and how it affected their behavior as parents.

The information gathering process was a valuable experience. We learned that the children most vulnerable to serious or fatal abuse and neglect are those whose parents or other caretakers are ill-equipped to care for them, who live in social isolation and poverty, and who are virtually invisible to the larger community and to the educational and child protective services systems. They tend to live in environments that have few supports for parents. They may not know their neighbors well enough to ask for help. It is disturbingly common for trial testimony in child abuse cases to reveal that family, neighbors, and even health care professionals suspected abuse but took no action.

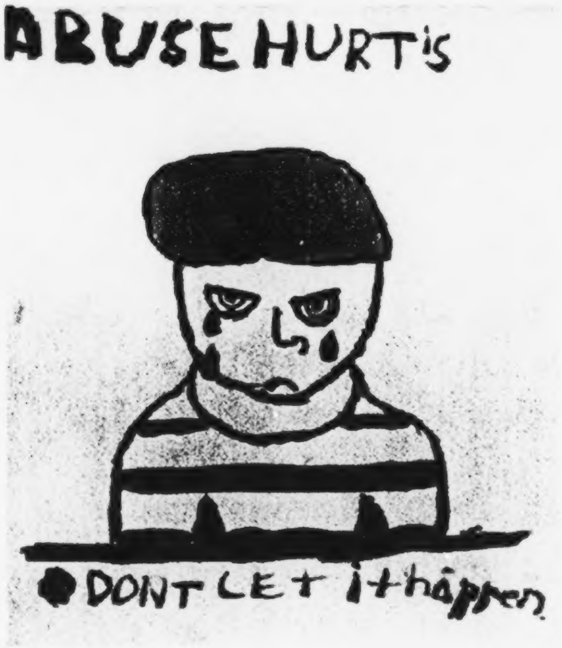
This is not to absolve parents for their actions. On the contrary, serious or fatal maltreatment of a child should carry the same criminal weight as comparable crimes against adults. But neither can the larger community be absolved from its responsibility for supporting parents and for protecting children.

Our greatest priority must be to help children and families before harm occurs. Breaking a household's isolation with appropriate preventive services, such as voluntary home visitation, respite day care or parenting education and support, can change an environment that is unsafe for a child. When prevention does not appear to work, then intervention on behalf of threatened children must be swift, professional, coordinated, and if necessary, permanent.

In both prevention and intervention, there is far more work that needs to be done. Our review has revealed serious gaps in data collection, support services for families, professional practice, and coordination and accountability among systems. Improvement in these areas can lead to better strategies and programs and will save lives.

There is so much more that we, as a nation, can and should be doing. We can strive to collect accurate and complete data on the number of children killed and injured every year. We can intervene in high-risk circumstances. We can expand basic support systems for families from the prenatal period all the way through the child's development. We can do a better job of sharing information among agencies to ensure that no child is seriously hurt or killed simply because one arm of the system did not communicate with the other.

While this Board is well aware of the current political trend toward consolidating child welfare and child abuse programs, giving more latitude to States to determine what services are provided and to whom, we believe that our Nation's response to the seriousness of children's deaths demands a strong local, State, and national focus. The majority of this report's recommendations require no new funds or bureaucracies, but would make a great difference in preventing child abuse and neglect and the loss of children's lives. Even where additional resources are needed, we can think of no better use for our dollars than to stop children from dying.



Anthony
New School for Child Development – Special Education Division

"A simple child,
That lightly draws its breath,
And feels its life in every limb,
What should it know of death?"
William Wordsworth

INTRODUCTION

In 1991, a riveting PBS documentary told the story of the brutal death of 5-year-old Adam Mann, beaten to death on March 3, 1990, by his stepfather, Rufus Chisolm, with participation by his mother, Michelle Mann. Many professionals had missed a series of signs that Adam was in serious danger. The autopsy demonstrated the cruelty Adam experienced in his short life. Over 100 injuries were observed on his body. The cause of death was listed as a broken skull, broken ribs, and a split liver. At one time or another, every bone in his body had been broken. There was no food in his stomach at the time of death. Adam's stepfather and mother were imprisoned, and Adam's siblings were placed in foster care.

The story of Adam Mann's death, as well as compelling testimony regarding other child abuse fatalities, prompted Congress to ask the U.S. Advisory Board on Child Abuse and Neglect (ABCAN) to prepare a report on child maltreatment-related fatalities. The report was to contain the Board's recommendations for:

- a national policy to reduce and ultimately prevent such fatalities,

- changes needed to achieve an effective Federal role in the implementation of the policy,
- changes needed to improve data collection about child abuse and neglect fatalities.

Given this important charge, the Board held an extensive series of hearings, workshops, and public forums, drawing upon the knowledge and experience of scholars, social work professionals, physicians, nurses, lawyers, teachers, child advocates, convicted child abusers and others with an interest in this topic. The information gained from this process is presented in this report, along with the Board's considered recommendations for actions that could reduce the number of child fatalities in the United States.

Thus, the Board presents this report in response to public concern, a congressional mandate, and its own longstanding belief that addressing child fatalities is a moral and ethical imperative to provide a critical perspective into the tragic lives of millions of other abused and neglected children. The Board hopes that its work, in some small way, will serve as a memorial to Adam Mann and to the thousands of fatally victimized children who cannot speak for themselves.

Must I light a candle to my shame?
William Shakespeare
Merchant of Venice

CHAPTER ONE

DEFINING THE SCOPE AND NATURE OF FATAL ABUSE AND NEGLECT

UNDERSTANDING THE PROBLEM

Our society has, in this century, kept a watchful eye on untimely child deaths due to everything from car crashes to contagious disease to poisonings. One can find out exactly how many children under the age of 18 died from gunshots by strangers in 1993 (FBI, 1994) and precisely how many children died from measles in 1970 (CDC, 1971). Last year, the Centers for Disease Control and Prevention (CDC) even began collecting information on child deaths due to accidents involving soccer goal-posts (personal communication, 1995).

Abused children died nearly three times more often than children hospitalized from auto crashes.

"You can call the Centers for Disease Control and Prevention and find the number of children who had a brown recluse spider bite last year, but you certainly can't get correct information on child abuse and neglect or fatalities." — Dr. Barbara Bonner, Center on Child Abuse and Neglect, University of Oklahoma, Oregon public hearing, 1993

Such detailed information has been used to identify the scope and nature of threats to children's health and safety and then to design prevention efforts that save lives, for example, the war on polio and the massive expenditures since 1983 on automobile safety seats for children.

But when it comes to deaths of infants and small children due to physical assault or severe neglect at the hands of parents or caretakers, society has responded in a strangely muffled, seemingly disinterested, way. Little money has been spent to understand this tragic phenomenon.

The true numbers and exact nature of the problem remain unknown, and the troubling fact of abuse or neglect often remains a terrible secret that is buried with the child. According to the General Accounting Office, Federal agencies spent only $5.7 million on research primarily relevant to child physical abuse, sexual abuse, and neglect in fiscal year 1989, and only a small fraction went to fatality research (Westover, 1990).

Childhood mortality rates were dramatically reduced in the United States by the success of sanitation measures early in the century, the development of antibiotics and immunizations, and strides in saving premature infants. However, no such societal investment of time and study has been made to reduce child fatalities from abuse and neglect. According to the Population Reference Bureau, death rates among children age 4 and under who die from homicide—the vast majority of which is committed by parents and caretakers—have hit a 40-year high (Mackeller & Yanagishita, 1995). Phil McClain of the Centers for Disease Control and Prevention believes that abuse and neglect kills 5.4 out of every 100,000 children age 4 and under (McClain et al, 1993; McClain, 1995). However, due to misclassification of child deaths, McClain believes that a second conservative estimate can be as high as 11.6 per 100,000 children age 4 and under (McClain, 1995). In comparison, the overall U.S. murder rate is 10 per 100,000 (Mackeller & Yanagishita, 1995).

> *"I was invited to the first national symposium on child maltreatment fatalities and was asked to bring data from my State. I called Vital Statistics, and they had six deaths due to abuse and neglect in the State. I thought, 'Boy, that's unusual. I know about more deaths than that myself.'"*
> *—Dr. Colleen Kivlahan, Medical Director, Department of Health, Jefferson City, Missouri*

Even these unacceptably high death rates may be underestimated. In its extensive 1993 review of the lagging efforts to understand child abuse and neglect, the National Research Council (NRC) of the National Academy of Sciences noted that recent research suggests 85 percent of child abuse and neglect deaths have been systematically misidentified (NRC, 1993; McClain et al, 1993; Ewigman et al, 1993). Of the cases studied, 38 percent were listed as accidents, 15 percent were listed as "homicides" with no indication that a parent or caretaker was the perpetrator, 15 percent were listed as Sudden Infant Death Syndrome (SIDS), 9 percent were listed as natural and 7 percent were listed as undetermined intentionality (NRC, 1993). This misidentification is due to poor medical diagnoses, incomplete police and child protection investigations, inaccurate or incomplete crime reports and flaws in the way the cause of death is recorded on death certificates (McClain et al, 1993; Ewigman et al, 1993).

As a result of these systemic problems, as well as the paucity of funding and lack of leadership to correct them, agencies that collect and monitor information on child abuse and neglect do not know how, why, or which children are dying. In 1993, the National Committee to Prevent Child Abuse (NCPCA) reported 1,299 known deaths by abuse and neglect (McCurdy & Daro, 1994). In 1992, the National Child Abuse and Neglect Data System (NCANDS), operated by the National Center on Child Abuse and Neglect (NCCAN), reported 1,068 deaths in 42 States (NCCAN, 1994). Yet the Federal Bureau of Investigation's (FBI) Uniform Crime Report (UCR) for 1992 listed only 788 murder victims under age 9 (1994).

It appears the most realistic estimate of annual child deaths from abuse and neglect, known and unknown, is about 2,000, *or some 5 children every day*. However, some experts believe the deaths may number 5,000 annually (Ryan Rainey, National Center for the Prosecution of Child Abuse, 1994 testimony).

"Depending on your role — child protective services, law enforcement, or medicine — your view of child abuse fatalities is quite different. We have to combine these views to get the full picture."—Jane Burnley, ABCAN Board member, New York workshop, June 16, 1994

What accounts for this broad-based ignorance of the extent of child maltreatment-related fatalities, an issue that should be of paramount interest to a country that deeply values its children? It is caused in part by incomplete data collection, inconsistent handling and tracking of cases, and little accountability among the law enforcement, medical, and child protection agencies responsible for investigating child deaths. It is equally related to unresolved differences in terminology used to describe the manner and cause of death; outmoded investigation and reporting practices by coroners, medical examiners, hospitals, and health agencies; and, finally, by the failure of any powerful leader or group to take on this crisis.

Public concern over this crisis is growing, in large part due to intense media coverage. Documentaries such as *Who Killed Adam Mann?* and media reports such as Gannett News Service's 1990 Pulitzer Prize-winning expose *Getting Away With Murder* and the *Chicago Tribune's* 1994 Pulitzer finalist *Killing Our Children,* do much to awaken the public to the horror of child deaths from maltreatment.

The American Professional Society on the Abuse of Children (APSAC), NCPCA, NCCAN, and Child Death Review Teams in 45 States are compiling and analyzing information on child fatalities. Their efforts to understand how many children die from abuse or neglect, and the manner and exact cause of death, are not simply about counting bodies. This Board agrees with extensive testimony presented to it in 1993 and 1994 from experts in dozens of disciplines, who made it clear that understanding the scope and nature of these fatalities is critical to developing a sound preventive response. Until we do understand, efforts to battle this threat to children will continue to rely on isolated decision making and fragile assumptions.

...understanding these fatalities is critical to developing a sound preventive response.

WHAT DO THE DATA TELL US?

Until recently, we were largely uninformed about the nature of child abuse and neglect deaths. The sometimes simplistic explanation inherent in the "Battered Child Syndrome" has gradually been replaced by a more sophisticated understanding gained through basic research and analysis of slowly improving data. We have learned a great deal about the differences between abuse and neglect fatalities, about who is most likely to be responsible for such deaths, what causes are indicative of maltreatment-related fatalities, which children are most likely to be the victims, and what happens to the survivors of near fatal maltreatment.

What Differentiates Abuse from Neglect Fatalities?

The data have demonstrated that abuse and neglect fatalities are two distinct maltreatment categories, requiring dramatically different prevention and treatment strategies. But neither category is yet fully understood. We have only recently begun an attempt to distinguish, for example, between "supervision neglect" deaths that involve critical moments in which the parent or caretaker is absent and the child is killed by a suddenly arising danger, and "chronic neglect" deaths caused by slowly building problems (Zuravin, 1991; Colorado Child Fatality Review Committee, 1993; Ewigman et al, 1993). With regard to the former, better public education and parenting training can serve to awaken parents and caretakers to the hidden, subtle dangers an unsupervised child faces.

On the other hand, ways to prevent the negative outcomes of chronic neglect, whether intentional or unintentional, are less well understood. Some experts believe that one promising method is to have "a second set of eyes" in the home, provided by programs such as voluntary home visiting by professionals or paraprofessionals or intensive, long-term monitoring of high-need families and their children by service agencies. This has inspired such efforts as Healthy Families America, a project of the NCPCA. This program holds promise, but will require several years to show verifiable results.

Many experts testified before this Board that child physical abuse deaths are the most difficult to reduce since they are the most baffling. But some answers are being provided by new research and analysis of data emerging from Child Death Review Teams. Teams in States such as Colorado and Oregon have identified specific "triggers" that occur just before many fatal parental assaults on infants and young children. These include a baby's inconsolable crying, feeding difficulties, a toddler's failed toilet training, and highly exaggerated parental perceptions of acts of "disobedience."

...some attacks begin with battering a spouse, then escalate to include the children.

In addition, some rage-based assaults are set off by stimuli other than the child. In the 1994 case of 5-month-old Roosevelt Bell in Chicago, the trigger was the outcome of a televised ball game. Roosevelt's father became so furious when his team lost that he beat the child to death (Martin, 1994). Domestic violence is another factor in abuse deaths. Preliminary research and early data suggest that some child abuse begins with the battering of a spouse, then escalates to include the children. The American Bar Association (ABA) reported that "children in homes plagued by domestic violence may themselves be abused within those homes at a rate much higher than the national average for child abuse ... overlap between households with both domestic violence and child abuse range from 40 to 60 percent" (1994, p. 18).

Identifying and understanding these patterns is critical to designing strategies to reduce such attacks. While specific "trigger" events are being identified, their causes and means of prevention have received very little attention, in part due to the scarcity of Federal and private funds devoted to physical abuse and neglect-related fatalities. We still do not know why some parents and caretakers respond with extreme violence to natural events in a child's life while other parents, suffering the same stresses, accept routine child-rearing challenges without resorting to violence (Levine et al, 1994; Levine et al, 1995).

Who Is Committing These Acts?

What sort of parent would attack or severely neglect a child in a manner that leads to death? In recent years we have learned that the average abusive parent is in his or her mid-20's, lives near or below the poverty level, often has not finished high school, is depressed and unable to cope with stress, and has experienced violence first hand. However, no single profile fits every case, and there are many exceptions to the "average."

One of the most interesting new findings that demonstrates the critical importance of better information is that most *physical abuse* fatalities are caused by enraged or extremely stressed fathers and other male caretakers (Levine et al, 1994; Levine et al, 1995). These men primarily assault infants and very small children by beating their heads and bodies, shaking them violently, intentionally suffocating them, immersing them in scalding water, and performing other brutal acts.

...most physical abuse fatalities are caused by enraged or extremely stressed fathers or other male caretakers.

Such findings have turned a common assumption upside-down: that mothers are the culprit in most abuse and neglect deaths. In fact, the adult most dangerous to an infant or small child is male—including birth fathers, stepfathers, and boyfriends. Studies show that mothers are most often held responsible for child neglect deaths from causes such as bathtub drowning, fires started by unsupervised children, dehydration, and starvation (Margolin, 1990). However, the supposition that the female is generally responsible can lead to unfair assignment of blame when a mother is held accountable for a neglect death even when the father was the parent in charge of the child. Clearly, these findings demonstrate a serious need for rethinking the design of prevention and treatment strategies that now focus primarily on females.

Another long-held belief contradicted by recent data is that fatal abuse and neglect are largely perpetrated by teenage or young single parents living alone. In fact, six studies undertaken since 1988 agree that the typical perpetrator is in his or her midtwenties, although many of them first became parents while teenagers. Moreover, most perpetrators are not raising their children alone. Bonner was surprised when her own study revealed that 60 percent of the children were killed while living with both biological parents (verbal testimony, 1994). Alfaro (1988) suggests that the majority of deaths occur in two-adult families where a male is present. Ewigman's 1993 Missouri study showed that married couples represented half of the perpetrators of abuse and neglect deaths.

Researchers have not identified a consistent set or cluster of personality traits that characterize extremely abusive and neglectful parents. Professionals who deal with such families report that many parents involved in fatal abuse and neglect are substance abusers with histories of child or spousal abuse or other violence. But little reliable data exist in this area and the scientific literature is lacking, (NRC, 1993) possibly indicating how little attempt is made by authorities to record evidence of substance abuse or other problems during child abuse and neglect investigations.

It has been long assumed that many parents involved in fatal abuse and neglect are affected by combinations of behavioral, emotional, and cognitive difficulties. Consistent with several decades of research, a recent study found that diagnosed mental illness is a factor in only a small percentage of child maltreatment cases (DePanfilis & Salus, 1992). While the extent to which intent figures into child fatalities is not known, two recent studies reveal that many fatal injuries must result from very violent attacks, suggesting that many parents are conscious of the damage they are inflicting (Kantor & Williams, 1993). Dr. Randell Alexander (1993) argues that while death caused by child abuse is often a matter of chance, the extreme force needed to inflict such damage on a child should have deterred any reasonable parent from such behavior.

What Are the Causes of Death?

Whatever the stimuli that lead to parents and caretakers killing children, fatal injuries from maltreatment follow a startling pattern of similarity. A study of child deaths in Oklahoma revealed that 29 percent of the children who die from abuse or neglect succumb to severe head trauma—a figure that has been replicated in studies by Colorado, Oregon, Los Angeles County, and other Child Death Review teams (Bonner & Thigpen, 1993). Similarly Shaken Baby Syndrome, an act so lethal that 20 to 25 percent of its victims die and that most survivors suffer brain damage resulting in lifelong cerebral palsy, visual defects, or cognitive impairment (Levitt et al, 1994), repeatedly appears as the cause of about 10-12 percent of all abuse and neglect deaths (Bonner & Thigpen, 1993; Colorado Fatality Review Committee, 1993). In a 34-State study of 216 fatal cases of Shaken Baby Syndrome, most perpetrators were men who became furious over a baby's crying (Showers, 1994). This is consistent with other evidence pointing to males acting out their frustration and rage by assaulting a child.

Shaken Baby syndrome is so lethal that 20 to 25 percent of its victims die, and most survivors suffer brain damage.

Assaults upon a child's abdomen, thorax, or both, while less common than head battering or severe shaking, leave such extensive internal damage that victims suffer a 40 to 50 percent fatality rate (Cooper et al, 1988; Sivit et al, 1989). Although less frequent, small children also die from intentional or preventable scalding, suffocation, drowning, and poisoning. These deaths may be related either to abuse or neglect.

Which Children Are Likely to Die?

Understanding which children die allows us to focus prevention and treatment where it will do the greatest good. Several new studies found that only 10 percent of child abuse fatality victims were older than age 4; most victims were under the age of 2 and 41 percent were under the age of 1 (McClain et al, 1993; Levine et al, 1994; Levine et al, 1995). Recent research also indicates that very young girls and boys are at equal risk of dying of the effects of maltreatment. Parents of very young children and infants, a group that has not received adequate attention in research, prevention, and treatment efforts or in legislation designed to address abuse and neglect, are clearly emerging as the critical population on which to focus.

Much remains unknown, however. For example, some earlier studies found that many of the youngest children who die from beatings had no previous signs of battering, suggesting that the attack upon them was the first incident (Abel, 1986). This implies that prevention of such deaths is highly problematic. Nonetheless, more recent studies demonstrate that many infants suffer numerous beatings before dying, indicating that they may have been seen by an official, family member, or neighbor who might have intervened to save them (Alexander et al, 1990).

What Happens to the Survivors?

One of the most alarming outcomes of life-threatening abuse and neglect by parents is the legacy of damaged and disabled children alive today who survived medical emergencies that would have killed other children. We are only now getting an early picture about the human costs of near-fatal abuse and neglect. NCCAN (1991) indicates that 141,700 children have suffered serious injury as a result of child abuse and neglect.

Nora J. Baladerian, after extensive review of the literature on disabilities caused by abuse, testified before this Board that the large population of children seriously injured and permanently disabled by abuse and neglect are "the survivors of the cadre of child abuse fatality near-misses," a view supported by Dr. Richard Gelles (verbal testimony, 1994). If one agrees with this view, luck plays a major role in determining which children live and which die.

Baladerian (1991) estimates that at least 18,000 children per year are permanently disabled by abuse or neglect, suffer mental retardation or sensory and motor impairments, and often require lifelong services at great cost. She suggests that at least ten times as many children survive severe abuse as die from it, and that a staggering 9.5 to 28 percent of all disabled persons in the United States may have been made so by child abuse and neglect (1991, p. 14).

...an estimated 18,000 children per year are permanently disabled by abuse or neglect.

However, there are no rigorous scientific findings on such disabilities (NRC, 1993). It is unknown, for example, how many of the 90,000 Americans left with brain damage from head injuries each year were made so by severe child abuse or neglect (Guzman, personal communication, 1995). Of children with head injuries known to be caused by abusive caretakers, however, it is known that many are left with lifelong cerebral palsy (Diamond & Jaudes, 1983).

Beyond the terrible human costs, Baladerian estimates that society spends an average of $20,000 per year for services throughout the life of each child with an acquired disability (Baladerian, written testimony, 1993). Clearly the millions now being spent to care for victims would be far better and more humanely spent developing services and strategies to prevent and reduce injuries. More extensive data and research on severe injuries and disabilities caused by abuse and neglect would help address this situation.

CURRENT ISSUES: OFFICIAL UNDERREPORTING, DEFINITIONS THAT OBSCURE ABUSE-RELATED CAUSES, AND POOR CASE-LEVEL DATA

New findings strongly suggest that policies, programs, and funding can be tailored to avoid efforts that target the wrong problems or populations and instead focus on those who need it most. But far more information is needed to mount an effective response. To acquire such information, a cohesive system to identify and investigate child abuse and neglect deaths, as well as to collect and interpret the resulting data, must be established.

Establishing a cohesive system is complicated by the fact that no identifiable entity is responsible for addressing child fatalities by abuse and neglect. For these children there is no equivalent of the March of Dimes or Mothers Against Drunk Driving. Attempts to understand the scope and nature of the problem still focus primarily on the most obvious deaths—those already identified as fatal abuse or neglect cases by law enforcement, child protection workers, or health authorities. Yet each of these three groups knows and tracks only one part of the child fatality picture. Since no one agency or source is sufficient to address this issue, a new, more comprehensive source must be developed.

Official Underreporting

Underreporting is a major obstacle to understanding fatal abuse and neglect. In Missouri, an exhaustive review of all child deaths by researchers and Child Death Review Teams, combined with broad government-led efforts to correct underreporting, has produced startling results in the past 2 years. The State has seen a doubling in child homicides recognized and coded on death certificates, a doubling in child abuse and neglect fatalities identified as such by the Division of Family Services, and a tripling in prosecutions of perpetrators (Ewigman, verbal testimony, 1994).

Missouri found underreporting at many levels. In 121 cases of verified fatal maltreatment among children age 4 and under, only 47.9 percent were given the necessary ICD-9 (International Classification of Diseases) code on the death certificate by a coroner, indicating abuse or neglect. The Division of Family Services substantiated only 79.3 percent of the cases as abuse or neglect fatalities, and the FBI's UCR recognized only 38.8 percent as homicides (Ewigman et al, 1993).

Child abuse and neglect fatalities are drastically underreported because of inadequate investigations, lack of information sharing between investigators and agencies, and outdated reporting systems that fail to capture maltreatment as the official cause of death. Moreover, each national source of information on child abuse and neglect deaths is rendered incomplete by its own design. We describe these sources and their problems below.

Child abuse and neglect fatalities are drastically underreported.

The Annual Survey by the National Committee to Prevent Child Abuse

The NCPCA, a nonprofit organization, deserves tremendous credit as the pioneer that first released annual national figures on child abuse and neglect fatalities in 1986. The NCPCA's data are the most frequently quoted by the media and policymakers. The survey is conducted at

NCPCA expense and gathers data via a 50-state telephone and written survey usually answered by each State's NCCAN liaison. Although in recent years the method of collecting information has become more rigorous, the data analysis is still a voluntary, private effort that does not give the full picture.

In 1993, with 37 States responding, the NCPCA reported 786 deaths known to child protective service (CPS) agencies and confirmed as due to abuse or neglect. The NCPCA estimates that all 50 States are actually aware of about 1,300 children who have died from abuse or neglect (McCurdy & Daro, 1994). It also estimates that about 40 percent of deaths are due to neglect, 55 percent to physical abuse, and 5 percent to both. The effort by the NCPCA is extremely important because it represents the most extensive, long-term attempt to gather aggregate information on child abuse and neglect fatalities.

> *"During our survey, I talked to a person in a State that's pretty good at data collection, and he said I could call on a different day of the week and ask him how many child abuse and neglect deaths there were, and it would be a different number. There are major problems." —Karen McCurdy, Principal Analyst, NCPCA, New York Focus group, 1994*

The Federal Bureau of Investigation's Uniform Crime Report

Another currently problematic source of data is the UCR, which is compiled by the FBI using information from State law enforcement agencies. Although the FBI receives data on child homicides by age, gender, and victim relationship to perpetrator, its published reports do not link these elements, to distinguish child homicides by caretakers. In addition, certain key data, such as whether the perpetrator was a boyfriend of the mother, are not included.

Nationwide implementation of the new National Incident-Based Reporting System (NIBRS) will permit an analysis of case specific data (e.g., linking the victim's age and relationship to the perpetrator). Even after NIBRS is more widely used, however, the UCR may still not contain enough information to assess abuse and neglect fatalities completely, because States have different definitions of child homicide and many fatalities are not identified as child abuse homicides. This is likely to distort which cases are reported to UCR. Moreover, some jurisdictions provide information to the FBI only when an arrest is made. Since arrests are often not made in child maltreatment cases, data from such cases may not be included.

The National Center for Health Statistics, Vital Statistics

A RECENT CASE:

The widely publicized Waneta E. Hoyt case in Newark Valley, N.Y., involved the loss of five babies in one family to Sudden Infant Death Syndrome. At the time of the deaths from 1964 to 1971, the Hoyts received much sympathy from the public and medical experts. Researchers published a seminal article theorizing that the five cases were inherited SIDS, which led to a recommendation of apnea monitors for some families. In 1992, however, a district attorney who had long been bothered by the case reopened the investigation. The District Attorney (D.A.) and state detectives gathered enough autopsy slides and notes from the original investigation to charge Mrs. Hoyt with smothering her children. The five deaths are still listed by Vital Statistics as SIDS, and there is little chance the death certificates will be corrected. Medical experts say the chances of three SIDS in one family are nearly one in a billion, the chances of five are virtually impossible. —*New York Times*, March 25 & 28, 1994, and Dr. Michael Baden, New York State Police Medical Examiner's Office, New York Workshop, 1994.

Vital statistics are collected by states from death certificates and then compiled and distributed by the National Center for Health Statistics. Death certificates are completed by coroners, medical examiners, or physicians who had been attending the deceased patient. Coroners and medical examiners are expected to note the cause of death (e.g., head trauma, pneumonia) and the manner of death (e.g., homicide, suicide, accident, natural, or undetermined). They may also include brief narratives for clarification. If the investigation and autopsy lead to a finding of child abuse or neglect, the cause, manner, and narrative on the death certificate should reflect that finding. Unfortunately, misdiagnosis and failure to correctly identify contributing causes in such deaths is still widespread. In addition, few coroners or medical examiners who do recognize a case as neglect or abuse actually fill out the forms with the level of detail required to indicate that abuse or neglect occurred (Kochanek, verbal testimony, 1994). Fewer still actually report the case to local authorities. In addition, while attending physicians are supposed to defer their decisions on cause of death to a medical examiner when the cause is not obvious, many do not (See Appendix E for a sample death certificate).

"Death certificates should include a check-off box to indicate child abuse and neglect as a cause of death." —Harry Wilson, M.D. Denver Focus Group, 1993

Medical misdiagnosis is common, because in many States, determination of the causes of a child's death is made by a coroner with little or no medical training. Even highly trained medical examiners may not recognize the often subtle medical signs of child abuse and neglect (See Chapter Two). Moreover, there is still widespread reluctance among coroners and medical examiners to implicate a child's parents or involve themselves in criminal cases.

Misdiagnosis is common in many States. Determination of the cause of a child's death is made by coroners, who often have little or no medical training.

In addition, coroners and medical examiners are under constant pressure to complete a death certificate quickly so that a child can be buried or cremated, often long before a police investigation is complete. As the Hoyt case illustrates, even if criminal investigators, CPS workers, Child Death Review Teams, or prosecutors later determine that a child was killed by abuse or neglect, coroners and medical examiners may not take the time to submit the information necessary to amend the original death certificate.

"FROM THE TRENCHES":

In 1992, over 3,700 children under the age of 15 died in Texas. Approximately two-thirds of those died within the first year of life, of which 40 percent died within the first month. Death certificates only identified about 10 of these as a result of abuse and neglect, yet CPS had about 100 mortality cases in their files alone. Neither number is correct.
— Richard Bays, State Registrar, Texas Department of Health, Dallas Public hearing, 1994.

Unclear Definitions and Poor Case-Level Data

Beyond the tremendous problems created by official underreporting, two key problems complicate the gathering of good data from official sources: the lack of definitions for what constitutes an abuse or neglect fatality and disagreement over data elements authorities should gather about the circumstances surrounding a child's death.

A major problem in identifying child abuse and neglect fatalities arises from the International Classification of Diseases system overseen by the World Health Organization. The CDC cannot fully assess the cause in child abuse and neglect deaths in part because the international code known as ICD-9, used to classify cause of death on death certificates, is "not up to par when it comes to certain causes, especially child-abuse or child maltreatment deaths" according to Phillip McClain of the CDC (verbal testimony, 1994).

"In many instances it's still called a natural death with no mention of child abuse or neglect if a child died of pneumonia and is covered with injuries including genital trauma."
— Dr. Michael Durfee, founder of the California and L.A. County Child Death Review Team systems, New York Focus group, 1994

The code's special category for specifying child abuse deaths is based upon an outmoded approach that narrowly focuses on the Battered Child Syndrome. The category is restricted to fatalities in which other abuse occurred *before* the events that caused the child's death (Kochanek, verbal testimony, 1994). Thus, if a 4-year-old dies of starvation due to withholding of food, but no previous incidents of abuse are detected, the death is generally listed as "natural" or "undetermined." Coroners and medical examiners can even choose "cardiopulmonary arrest," which simply means the child's heart stopped beating and the lungs failed. This is not a cause, but a definition of death.

Insufficient Data Collection on Individual Cases

As long as one agency collects data on a dead child's age, but nothing about family income, and another collects data on past incidents of family abuse, but nothing about whether the parents were substance abusers, we will gain little insight into the complex matrix of social problems of which these tragedies are usually a part. Only about 25 States report to NCPCA the ages of children who die from abuse or neglect—a key issue in creating prevention programs. Other important details simply are not given (McCurdy, verbal testimony, 1994).

"Until we get some case-level data, which I know we're just starting to do, we're not going to be able to identify any relationships which are going to suggest ways to prevent fatalities."—Karen McCurdy, Principal Analyst, NCPCA, New York Focus group, 1994

With a detailed description, critical questions could be answered and factors could be pinpointed that characterize certain types or clusters of death. Once identified, these factors may suggest ways to launch better public education campaigns and design more effective public policy.

Highly Inadequate Research Efforts

This Board heard from dozens of experts nationwide who disagreed in many areas but shared one profound frustration: the failure of the Federal Government, States and private foundations to provide the level of research monies that are justified by the 2,000 deaths and 141,700 serious injuries each year caused by child maltreatment (NCCAN, 1991). This is compounded by the failure of scientific organizations and universities to initiate research on serious and fatal child abuse and neglect.

Given the small amount of research funds available, it is all the more unfortunate that many studies are conducted by groups with little experience that may fail to use scientific methods, control groups, sufficient samples or other minimum requirements for producing meaningful information (NRC, 1993).

Indeed, the disparate information gathered thus far provides no answers to the most pressing question: Why do parents kill their children or become so neglectful that their children die? Investigators disagree on whether abuse and neglect represents a continuum of behaviors ranging from mild physical discipline to severe abuse and neglect, or a set of unique behavioral problems with distinctive etiologies (Gelles, 1991). Since no single risk factor has been identified, the focus is upon multiple risk factors that may overtake the protective behaviors parents normally demonstrate.

One mystifying issue is the large overrepresentation of African American families in known child abuse and neglect fatalities, which is twice or three times the rate seen in other racial groups. The data show a dramatic overrepresentation of African Americans in fatal abuse and neglect deaths, but there has been almost no study to understand this issue. Yet the numbers should deeply concern policymakers and the public: one study showed the homicide rate of African American infants studied over a 10-year period to be 25 per 100,000. This approaches the rate of violent death for African Americans (39 per 100,000), which, in contrast, is a widely discussed area of concern (Levine et al, 1994; Levine et al, 1995).

Many researchers believe that discussions of race obscure the true contributing factor—poverty, which affects roughly one in two American Indians and one in three African American and Hispanic families, but only one in nine white or Asian families (American Almanac Statistical Abstract of the United States, 1994). However, while poverty afflicts nearly one in three Hispanics families, they do not appear to be overrepresented in fatal child abuse and neglect (Robinson & Stevens, 1992).

Others have suggested to this Board that the problem is not poverty, but psychological stress caused by dealing with limited opportunities and the effects of racism. These important questions remain unanswered.

STRATEGIES FOR IMPROVEMENT

Seeking Common Definitions and Data Elements

Common definitions and data elements are critical

Common definitions and data elements are critical to making meaningful comparisons of the cause and manner of child deaths, and to developing prevention strategies. Uniform data-reporting protocols are necessary since any single jurisdiction will have only a small number of cases for statistical analysis. Large numbers of cases are desirable for study. But data cannot be combined unless collected in a reasonably uniform manner in all jurisdictions. Greater uniformity will require extensive literature review, research, and consensus-building that involve State and local agency representatives, researchers, and data collection and analysis experts.

Use of Estimation Models by the Centers for Disease Control and Prevention

The CDC has developed promising estimation models that should be given high priority. McClain et al (1993) have attempted to analyze existing data sets to estimate prevalence rates and patterns of fatal abuse and neglect. In the long term, estimation should be replaced by accurate counts of actual cases. This Board is particularly interested in analyses of rates of death, since the figure for total child abuse and neglect deaths will undoubtedly grow as the Nation's population grows, while increases or decreases in the rate will give a true picture of the effectiveness of intervention and prevention strategies.

Sending a Clear Public Message

A lack of communication and cohesion exists within the loosely connected groups that generate and collect data on childhood deaths from abuse and neglect. Further study of various data from CPS agencies, State agencies that gather vital statistics, and the FBI's UCR could be encouraged and overseen by the CDC. In addition, regular communication should be instituted among these three entities in order to avoid sending confusing and sometimes contradictory messages about the scope and nature of fatal child abuse and neglect to the public , policymakers, and practitioners.

> *"In Missouri, rather than having motor vehicle injuries as the leading cause of trauma death (for infants and small children), our studies show that maltreatment was the leading cause of death. That really created deep concern among the state's legislators: leading cause of death." — Ying Ying T. Yuan, New York Focus group, 1994*

For example, in 1994 the Department of Justice (DOJ) released a report *Murder in Families*, which identified mothers as the most frequent killers of children (Dawson & Langan, 1994). The DOJ data appear to reflect who is prosecuted and convicted. However, this information was misconstrued by television networks and major newspapers, and was cited as proof of a looming "mother" problem. As we have made clear, it has been shown by several new studies that go beyond prosecution and conviction figures that fathers and other male caretakers account for significantly more abuse and neglect deaths than mothers or other female caretakers. Yet this information is not reaching those who should hear it. This Board believes such critical communication problems can be addressed through an annual release of data that provides the media and public with a single, consolidated source of information.

A New Effort by the National Child Abuse and Neglect Data System

One hopeful development is the NCANDS, a project of the NCCAN, to collect case-level information on child abuse and neglect cases. The information will come from data gathered by CPS agencies and Child Death Review Teams and complied by statewide child abuse indices. So far, 20 States have agreed to participate annually (Ying-Ying T. Yuan, verbal testimony, 1994).

The NCANDS technical assistance contractor team is actively working to help all 50 States build their technical capacity to provide child fatality data and is working with them to agree upon definitions of the phenomena. Moreover, the NCANDS team is also helping States correct data from previous years.

> *"What you'll find is that 80 percent of these fatalities occur in 10 percent of the census tracts in any given community. If you're going to research the child fatalities in these census tracts, you've also got to map the other violence and homicide in that community. Otherwise, you're not going to get the picture."*
> *—Richard Gelles, Family Violence Research Program, The University of Rhode Island, New York Focus group, 1994*

Greatly Expanded Research Efforts

We believe it is time for Congress, States, private foundations, and universities to dramatically increase research in this poorly studied field. The Board recommends several critical areas where research is needed in Recommendation 2.

...it is time for Congress, States, private foundations, and universities to dramatically increase research in this poorly studied field.

In 1993, the NRC called for States to pool their research efforts on complex topics, such as the efficacy of abuse and neglect intervention programs, in order to create better-funded, larger, and more rigorous evaluation groups in an era of restricted budgets (NRC, 1993). In addition, the NRC called for a doubling in research budgets by the end of 1996 within NCCAN, the National Institutes of Mental Health (NIMH), the National Institute of Child Health and Human Development (NICCHD), CDC, and DOJ. This would increase to $30 million the estimated $15 million now earmarked for study primarily relevant to child abuse and neglect (NRC, 1993). We wholeheartedly concur with the need for this federal expenditure.

The Emergence of Child Death Review Teams

A growing number of States and communities offer a way to integrate data collection and discover patterns and causes of child abuse and neglect deaths through the efforts of Child Death Review Teams, which are described in detail in Chapter Three. The teams involve health, social service, and criminal justice professionals in a multiagency, confidential forum. They review the various systems' involvement with children and their families before and after a child's death. Teams often identify abuse and neglect fatalities that were missed by individual agencies. These teams appear to offer the best hope for an accurate count of fatalities and detailed information on the circumstances surrounding such deaths.

> *"We spend so much money researching and analyzing the cause and prevention of airplane deaths, yet the number of airplane victims is a fraction of the number of child homicides."—Paul DerOhannesian, Albany Assistant Prosecutor, Oregon public hearing, 1994*

We are a long way, however, from relying upon Child Death Review Teams to gather the information needed to create a comprehensive national child death data system, or to promote meaningful laws and programs that would arise from such a system. Although most States have a statewide review team and many urban and rural centers have a local review team, the majority of communities still do not. Thus, it may be some years before the teams serve as a national source of information on the true nature and scope of abuse and neglect deaths.

CHAPTER ONE RECOMMENDATIONS

Significantly reducing fatal child abuse and neglect, and the attendant social and economic costs of severe abuse and neglect among survivors, requires the highest level of attention, a far more sophisticated understanding of the problem, and a much greater commitment of resources. For this reason, ABCAN recommends:

Recommendation 1: Our Nation must establish a national commitment at the highest levels to understand the scope and nature of fatal child abuse and neglect.

We urge the U.S. Attorney General and the Secretary of the Department of Health and Human Services (DHHS) to devote existing resources and expertise to address the lack of knowledge regarding the true nature and extent of child abuse and neglect fatalities in America.

To accomplish this, the CDC, NCCAN, DOJ, State and local agencies, and Child Death Review teams must work across many disciplines to identify these deaths more effectively when they occur. An existing mechanism for interagency collaboration, the Interagency Task Force on Child Abuse and Neglect, should be utilized to further these efforts. Such efforts should include:

- Development of a uniform definition of child abuse and neglect fatalities.
- Uniform completion of death certificates to accurately record child abuse and neglect fatalities.
- Establishment of uniform data elements for collection and analysis (e.g., age, gender, previous abuse or neglect reports, substance abuse, domestic violence, relationship of victim to suspect). DHHS and DOJ should provide leadership in developing common data sets to be collected by investigators and Child Death Review Teams.
- Linking of data generated by different agencies, including child

welfare agencies, criminal justice agencies and public health. States should integrate information from multiple sources in annual reports on the nature and extent of child abuse and neglect deaths.

- Collaboration and analysis of national data spearheaded by Federal agencies and national associations. DHHS and DOJ could create or contract for a special component to collect child abuse and neglect fatality data from States operating with, well-established Child Death Review Teams.

Recommendation 2: Federal and State agencies must significantly increase research efforts on serious and fatal child abuse and neglect.

We concur with the NRC's call in 1993 for a doubling from $15 million to $30 million, in Federal research on child abuse and neglect by DHHS (NCCAN, NIMH, NICCHD, CDC), and DOJ. We urge that a significant portion of the increase go to issues involving severe and fatal abuse and neglect. We also urge States to devote more research funds to this crucial issue.

We recommend emphasis in the following areas:

- Research into the role of socioeconomic correlates, such as poverty and race, in serious and fatal child abuse and neglect.
- Research into the role of behavioral correlates, such as substance abuse and domestic violence, in serious and fatal abuse and neglect.
- Research into the effectiveness of current services in preventing fatality and serious injury and the effects of offering no services at all. Such research should also examine which kinds of parents are amenable to services and treatment.
- Research into "trigger-reaction" behavior and its causes, including why some parents or caretakers respond violently to stressful behavior and others do not.
- Research into the overrepresentation of African Americans as victims and as perpetrators of child abuse and neglect fatalities.
- Research into the discrepancies that may exist in services and interventions offered to different economic classes, ethnic, and racial

groups, and whether this affects child safety.

- Research into the current effectiveness of, and ways to improve, Child Death Review Teams in identifying abuse and neglect deaths, promoting system improvements, and creating meaningful prevention strategies.
- Research into the designing of better "risk assessment" tools that help professionals decide which families are at risk of serious abuse, and what intervention is required.
- Basic research into the medical aspects of serious and fatal abuse and neglect, including the role of abuse and neglect in causing permanent disabilities.
- Comparative study of the effectiveness of existing interventions, such as family preservation and family support programs, foster care, family maintenance services, and termination of parental rights in reducing serious and fatal abuse and neglect.
- Comparative study of multiple factors in families of children hospitalized for fatal and near-fatal injuries from accidental and intentional causes. Such research will help to determine incidence, and risk factors, and effectiveness of multiagency interventions assessing fatal and near-fatal injuries will increase the base rate for comparison.

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"In the little world in which children have their existence,
Whosoever brings them up,
There is nothing so finely preserved and so finely felt as injustice."
Charles Dickens
Great Expectations

CHAPTER TWO

ADDRESSING SHARED RESPONSIBILITY: CASE INVESTIGATION AND PROSECUTION

CASE INVESTIGATION AND PROSECUTION

When a child dies in America today at the hands of an abusive or neglectful parent, there is too often a lack of accountability on the part of government agencies, front-line professionals, and the perpetrator. Such deaths often fall through the cracks between the many organizations, including law enforcement, medical, judicial, educational, and social service agencies that comprise the child protection system. No mechanisms exist to assure that responsibility is taken within this multiagency system for determining how and why a child dies, or who should be held accountable. As noted by the Congressional Research Service, many law enforcement systems investigate child deaths only if a coroner's autopsy finds the death suspicious; yet coroners do not consistently assure that children are autopsied (Robinson & Stevens, 1992). When autopsies are ordered, they may be incomplete or incompetent.

"Good systems will emerge from well-trained people." — Michael Wald, Deputy General Counsel, DHHS, Board member, ABCAN meeting, Washington., 1994

In short, nobody speaks loudly enough for the children when these tragedies occur. The system created in the United States to ensure that adult homicides are thoroughly identified, investigated, and prosecuted is failing to serve infants and children who die of maltreatment.

In times past, children were often seen as property. Many police, judges, and prosecutors viewed such deaths as a strictly social problem, not a criminal issue. Today, systemic problems created by those attitudes linger.

The Child Protection System of Mandated Reporters and Agencies

Many of the key agencies that make up the child protection network do not understand their role in abuse and neglect investigation procedures or in assuring a child's safety. The holes in the safety net can easily be seen in the numbers of front-line professionals from education, law enforcement, medicine, and other fields who do not notify child protective service (CPS) agencies about children they suspect of being abused or neglected, even though they are legally mandated to do so.

A recent study found that 69 percent of professionals who suspected abuse did not report it.

Zellman et al (1990) found that 22 percent of these mandated reporters, who include pediatricians, school principals, and day care operators, do not report suspected abuse, citing as top reasons their lack of hard evidence of abuse or neglect—which, in fact, is not required for a report—and their belief that "I can do better than the system." A recent study found that 69 percent of professionals in medicine, law enforcement, and other fields who suspected abuse did not report it to CPS or any other authority (Reiniger et al, 1995). They are often breaking State law.

The ineffectiveness of the mandated reporter system was made clear in 1988 by the National Committee to Prevent Child Abuse's (NCPCA) National Telephone Survey. It found that teachers, who are considered among the most critical members of the system, receive little education in identifying, reporting, or intervening in suspected child abuse and neglect. Less than half of the teachers had ever attended an inservice workshop on child abuse or neglect. Of those, half believed their instruction was insufficient (McCurdy & Daro, 1988). According to testimony, mandated reporters suffer a "serious knowledge gap" about how and when to report abuse (Reiniger, verbal testimony, 1994).

Such practices among individuals who are supposed to be protecting children become extremely important in light of the number of abused and neglected children who die before anyone alerts a CPS agency. Martinez and Sommer (1988) found that while 40 percent of the children who die from abuse and neglect are under age 1, such children account for only 13.8 percent of abuse cases substantiated by CPS agencies.

"Teachers saw my bruises. They saw what I was going through. I went from an honor student to a kid that didn't have no respect for authority, all of a sudden. Do you understand what I'm saying?"—A Woman of the Family Violence Program, Bedford Hills Correctional Facility, 1994

There even have been cases reported where professionals have sought to protect the perpetrators. Helen Shore, Regional Coordinator, Child Fatality Review Project, Neosho, Missouri, told the Board of a Missouri coroner who wanted to label a case of inflicted suffocation as Sudden Infant Death Syndrome to protect a family's reputation (verbal testimony, 1994).

A few States are making some attempt to address the lack of training for mandated reporters. For instance, California requires 8 hours of training on child abuse and neglect for licensure of family therapists including psychologists and licensed clinical social workers, though not for physicians. Iowa requires 2 hours of training every 5 years for mandated reporters. New York requires 2 hours of initial training for mandated reporters. Any efforts to train mandatory reporters should provide them with skills to recognize the signs of potentially fatal child abuse and to act quickly on their suspicions.

The Role of Child Protective Services

Testimony before this board in 1993 and 1994 indicated a widespread lack of faith in CPS investigative efforts and in CPS' role in detecting or reducing fatalities from abuse or neglect. Many overburdened CPS agencies, although expressly mandated to protect children, "do not see themselves as having a serious role in investigating maltreatment deaths, due to the criminal implications" (Beveridge, verbal testimony, 1993).

> *"I believe in my heart if CPS had monitored and had me go to counseling with my mother, something might have been done. But if you say you are going to monitor and you don't ever come, and when you decide to come you call me first, that gives me a chance: 'Put on the long sleeves, honey.' Clean up, and all that."— A Woman of the Family Violence Program, Bedford Hills Correctional Facility, June 1994*

Many professionals do not trust CPS to conduct thorough investigations of nonfatal abuse or neglect cases before listing them as "unsubstantiated." In cases where children die or are severely injured after CPS investigated and dismissed reports of abuse or neglect, States sometimes take criminal action against CPS workers.

In 1992, 1.9 million reports of abuse and neglect involving 2.9 million children were received by CPS agencies, a figure which includes multiple incidents within some families (NCCAN, 1994). While many States purge unsubstantiated abuse and neglect cases to prevent families from being kept in CPS records, a few States have chosen to keep unsubstantiated cases on file. Many experts argue that retaining unfounded reports allows caseworkers to detect past patterns of abuse when investigating new allegations that a child is in danger (Reininger, verbal testimony, 1994). Today, Child Death Review Teams and police, who routinely review records of deceased children, consider prior reports of unsubstantiated abuse to be potentially important aids in gathering evidence in those States where records are saved (Smith, verbal testimony, 1994).

The Role of Prosecution

Even after a fatality caused by abuse or neglect is recognized and an investigation is launched to identify a perpetrator, the criminal justice system often responds insufficiently. The Board heard the testimony of prosecutors who conceded that charges of child homicides, including heinous cases, are routinely reduced to lesser crimes.

Charges of child homicides are routinely reduced to lesser crimes.

Prosecutors reduce charges or do not charge perpetrators at all because existing murder statutes do not fit many child abuse and neglect fatalities and cases can be difficult to prove in court. For example, most prosecutors have little or no experience with abuse and neglect cases; police often fail to gather sufficient evidence; and autopsies are seldom performed by medical examiners with pediatric expertise. Witnesses are rare aside from the perpetrator because most deaths occur in the privacy of the home, and some juries simply cannot believe that any parent or caretaker would commit such acts upon a child.

> *"The goal must be to prosecute child homicides as aggressively as we now prosecute adult murders. To be successful, the greatest barrier to achieving equal justice must be overcome--the public's disbelief." — Ryan H. Rainey, Senior Attorney, National Center for Prosecution of Child Abuse, Los Angeles Focus group, 1994*

In one example of an attempt to anticipate jury disbelief, a Peoria, Illinois, prosecutor waited 7 months to issue a charge of manslaughter against an aunt who killed her baby nephew with a stun gun. Brandon Jordon, age 7 months, died from multiple assaults from a 70,000-volt stun gun. Police say the aunt shot the baby on May 28, 1994, to stop his crying. Authorities were uncertain if they could convince a jury that anyone could commit such a terrible act, and prosecutors delayed charging the aunt while "investigating the effects of stun guns on children" (Staff, *Peoria Journal-Star*, June 30, November 24, November 29, 1994).

A Struggle for States

Several States have tried to address the many troubling issues presented by the flaws in investigating and prosecuting abuse and neglect deaths. Colorado has established guidelines for the role of CPS, law enforcement, and health professionals when investigating suspicious child deaths. Oregon provides clear guidelines for the specific roles of all professionals involved in death investigations: CPS workers are expected to provide case management information and family history to investigators, and police are expected to report witness information and provide scene photographs, physical evidence, and background and suspect information. Health professionals are expected to provide thorough analyses of deaths through autopsies.

Most experts believe that thousands of families in which a child died in the past decade, whether known to CPS or not, were often well-known to a physician, police officer, probation or parole officer, welfare worker, therapist, or other professional. Indeed, many of these families have multiple problems including drug abuse, domestic violence, unemployment or homelessness that bring them in frequent contact with such agencies. However, few front-line professionals have the training or knowledge to respond to the dangers to children from abuse and neglect.

"Researchers spend a lot of time investigating how CPS agencies failed when a death occurs, but in most cases CPS was not aware of that family or that child's existence before the death. But somebody, somewhere, was aware."—Jose Alfaro, Director of Research, Children's Aid Society, New York Focus group, 1994

With such basic, deep-rooted problems, it is not hard to see why the system seems to have fallen into disarray when yet another tragic death of a child is made public in the media. All concerned professionals and agencies must help carry the weight that cannot be borne by CPS alone and become active participants in identifying and reporting abuse and neglect. That effort will hinge, to a large degree, upon a complete rethinking of how we train and guide the people on whom these responsibilities rest.

Provision of Available and Necessary Medical Care to Children

A particularly difficult issue that was brought to the attention of the Board during the preparation of this report, is the issue of religious exemption or religious immunity or deference in cases of medical neglect of children. These phrases have been used to refer to the policies and laws which seek to exempt or immunize parents of children who do not provide available and necessary medical care to a child because of their religious beliefs. This issue involves balancing constitutional guarantees of freedom of religion, parental rights, and societal and governmental responsibilities to protect children from serious harm or death.

The right of a person in the United States to practice his or her religious beliefs is a key principle in our Nation's history and is clearly articulated in the Constitution. Government must not seek to limit that right. However, government has enacted important laws that are designed to protect the health and well-being of children, who because of their very nature are dependent upon their parents for care, nurturing, and protection. Such laws provide for governmental intervention to ensure that a child will have access to available medical care when the child has been harmed, or is at substantial risk of harm. At present, this can be accomplished through the application of child abuse reporting, investigation, and treatment laws in each State.

This issue has been complicated by Federal statutory and regulatory changes that have evolved over the past two decades. The Federal Government became involved with this issue in 1974, following the enactment of the nation's first Federal child abuse statute, the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93-247, as amended). Regulations implementing CAPTA directed that, in order to receive Federal funds under this new grant program, States had to construct their civil child abuse statutes in such a way as to ensure that "a parent or guardian legitimately practicing religious beliefs who thereby does not provide specified medical treatment for a child, for that reason alone shall not be considered a negligent parent or guardian." The regulation went further to indicate that "such an exception shall not preclude a court from ordering that medical services be provided to the child, where his health requires it."

Against a backdrop of heightened awareness and concern about the problem of child abuse and neglect and the desire to take advantage of the financial incentive in this area, most States enacted child abuse and neglect reporting laws that exempted or immunized parents from a finding of negligence if their failure to provide medical treatment was based on religious beliefs. Some States amended their criminal statutes as well, prohibiting prosecution of parents who did not provide medical care for their children, regardless of the outcome.

Throughout the next decade state child protective services expanded and reports of abuse and neglect grew tremendously. In addition, reports of instances in which children became seriously ill, disabled, or died due to a lack of medical treatment came to the attention of CPS agencies, the courts, and the Federal government.

In 1983, the Department of Health and Human Services (DHHS) issued new regulations addressing medical neglect. To continue to receive federal CAPTA funds, States then had to explicitly add medical neglect to their child abuse statutes. In addition, the Department dropped the requirement that States have religious exemption or immunity provisions and clarified that while states may exempt parents from being adjudicated as negligent, the State must have the authority to intervene to protect the child and provide necessary medical care.

In recent years, as the DHHS has continued to review States' child abuse and neglect statues to determine whether they meet the requirements of CAPTA, some States have lost Federal funding and others were influenced to change their laws related to the medical care of children. In 1995, Congress imposed a moratorium on DHHS action with respect to these laws.

Although the Department's policy has been consistent since the issuance of the 1983 regulations—all children are entitled to available and necessary medical care, regardless of the religious beliefs or practices of their parents or guardians—this aspect of the child abuse Federal policy has been the subject of recurrent debate. It has reportedly caused confusion among many child protection agencies regarding their authority to intervene in reported child medical neglect cases if the parent's action or inaction based upon their religious beliefs. In an effort to clarify this issue, some States have added spiritual healers to their list of mandatory child abuse reporters. The courts in various States have interpreted the religious exemption or immunity statutes differently: some have upheld criminal prosecutions of parents whose children suffer serious disability or die as a result of religion-based failure to seek or provide necessary medical care while others have ruled that the States religious exemption or immunity prevents such prosecutions.

Medical professionals and child advocates have voiced increasing concern that continuation of the current policy will endanger more children because children who are at risk of serious harm as a result of a lack of medical treatment often do not come to the attention of medical or child protection professionals until the situation is critical or after the child has died or suffered permanent injury. In addition, there is concern that the current policy undermines the legal responsibility that all parents have to care for their children and sends a confusing message to parents, spiritual healers, and professionals involved in the child protection system.

It appears that the religious exemption, religious immunity, or deference provisions regarding medical care of children in some State statutes may have created unintended barriers to the provision of timely, necessary medical care for children. After lengthy consideration, the Board is concerned that such an exemption leads people to fail to report cases of inadequate medical care to appropriate authorities. The results have proven to be devastating in a number of widely reported cases.

The reauthorization of CAPTA and the Federal role in child abuse and child welfare programs is under review in the Congress this year. However the Congress may decide these questions, the compelling issue of protecting children who may be denied needed medical care remains. Therefore, the Board recommends that States take action to ensure the protection of all children.

CURRENT ISSUES: TRAINING WEAKNESSES

A RECENT CASE:

The 5-year-old was brought to Lincoln Hospital in the Bronx four times over several months, each time with a different injury: a skull fracture, extensive bruising, cigarette burns on her hands and chest, and severe scalding from hot tapwater. On her final trip, she was DOA. An autopsy revealed that she died from a lacerated liver, the result of being severely punched. When the Medical Examiner collected hospital records, he noticed that a different doctor had seen the girl each time, and the seemingly caring family always gave a history of accidents—a clumsy little girl who put her hands in ashtrays, stepped into scalding water, or fell down a flight of stairs. Each time, the new doctor, untrained in the signs of inflicted abuse, believed the story.—Dr. Michael Baden, New York State Police Medical Examiner's Office, New York Focus group, 1994.

The greatest impediment to creating competence among professionals who respond to child deaths is the lack of specialized training and crosstraining. From the time of death, while a child's body lies motionless on a hospital bed or at home in a crib, to the time of reckoning, when a parent or caretaker is brought before a judge, a lack of expertise on the part of front-line professionals infuses the process with confusion and missed clues.

The system is so strained that the question of who harmed a child may never be asked or answered, and in too many cases perpetrators have gone on undetected to harm or kill other children. Sometimes this is due to a lack of crosstraining which is necessary for effective coordination among agencies. It is not unusual for law enforcement to be aware of domestic violence problems in a family, for CPS to know about an allegation of molestation against the mother's boyfriend, and for public health nurses to be tracking an infant in the home suffering from

"We have become experts at finding someone to blame, but somewhere right now, a child is dying at the hands of his/her parent or caretaker, and we don't know how to find them in time."—Yvonne Chase, ABCAN Board member and Deputy Commissioner, Department of Health and Human Services, State of Alaska, ABCAN meeting, 1994

malnutrition or failure to thrive. Yet more often than not, none of this information is seen in its entirety by any one professional.

Some States are using the knowledge gained from Child Death Review Teams to dramatically improve training and awareness. In Missouri, for example, training developed by experts from Child Death Review Teams is regularly conducted at association meetings of coroners, prosecutors, and others. However, other regions appear to be moving in the opposite direction. In New York City, for example, the child protective training academy is being dismantled and transferred out of the child welfare system. According to Dr. Megan McLaughlin, Executive Director of the Federation of Protestant Welfare Agencies, the critical training of case workers has been made an expendable part of the child protection program (verbal testimony, 1994).

Physicians and Other Hospital Personnel Are Unaware of Abuse Clues

A RECENT CASE:

In Rhode Island, a battered woman appeared at a hospital emergency room with her bruised toddler. None of the doctors or nurses who treated the mother examined the child, and after the woman was patched up, no one thought to notify CPS. Nine months after the mother's visit to the ER, the baby was killed by the same violent boyfriend who had been beating the mother. A member of the Child Death Review Team noted, "The child died essentially because of the failure of an emergency room to identify risk, witnessed through the serious abuse of the mother." —Dr. Richard Gelles, Family Violence Research Program, University of Rhode Island, New York Focus group, 1994.

Several medical examiners testifying before this Board gave detailed accounts of hospital cases where the presence of child abuse or neglect was not ascertained until autopsy. In many cases, the medical examiners believed the cause of the child's injuries should have been determined, or at least questioned, by those who treated the child in an ambulance, in an emergency room, or in intensive care. Child Death Review Teams have found that because many emergency rooms are staffed by rotating physicians with various specialties, an abused or neglected child might be seen by a physician who is unaware of the health records of children and is unprepared to recognize the symptoms of child abuse or neglect (Minnesota State Department of Human Services, 1991).

Moreover, unknown numbers of children never make it to a medical examiner for autopsy because of a lack of training and awareness among emergency room and intensive care workers, emergency medical technicians (EMT's), and other medical personnel. Often, the true cause of death remains a mystery, and the parent or caretaker is treated as a bereaved victim.

Despite the dimensions of this life-threatening medical crisis, only 400 pediatricians nationally have membership in the American Academy of Pediatrics (AAP) Section on Child Abuse. In States as large and populous as Texas, that translates into less than 10 pediatric specialists, all of whom are on faculty at medical schools (Garcia, 1994 testimony.) Because child abuse is not a defined specialty in pediatrics, it is not required as a rotation during pediatric residency training.

"Doctors, especially younger doctors, want to believe that parents only beat older children. I have to keep telling them, no, they beat babies."—Dr. Margaret McHugh, Child Protection Team, Bellevue Hospital, New York Focus group, 1994

Few Medical Examiners or Coroners Know How to Detect Child Abuse and Neglect

The vast majority of medical examiners and forensic pathologists lack specific training in identifying the cause of a child fatality, and only a handful of medical examiners in the country specialize in autopsies of children. Moreover, although there is a new certification specialty for pediatric pathology, there is no certification requirement for medical examiners or forensic pathologists who autopsy children.

These problems represent a significant weakness in the system because children succumb to unique and sometimes subtle injuries and maladies from abuse and neglect that are easily missed by an examiner trained to find causes of adult death. Moreover, parental deceit and denial are common. Complicating the situation, 28 States rely upon coroners or justices of the peace who are elected to office based only on the qualifications that they are at least 18 years of age and a resident of that county (CDC, 1993).

"No parent or guardian ever comes in and says 'I've been beating up my child.' They always say, 'The kid fell down, a dog jumped on the kid, a swing hit the kid.' For medical examiners, it is critical to detect the injuries that show the child couldn't have done it to himself."—Dr. Michael Baden, Chief Medical Examiner, New York State Police, New York Focus group, 1994

Most States have very limited funding and do not provide autopsies and death scene investigations for all unexplained deaths, particularly for children. As Gannett's 1990 series showed, "autopsies on children are conducted almost by whim." The series found that four Southern States examined, on average, only 31 percent of dead children, compared with five Western States that autopsy, on average, 54 percent of dead children—the highest national average (Gannett News Service, 1990). Gannett found that, nationwide, one in every 12 SIDS deaths is diagnosed as SIDS without support of an autopsy—a flagrant violation of necessary medical procedure (Lundstrom & Sharpe, 1991). In Pennsylvania, many local coroners are reticent to perform autopsies on any child, and very often do not have the funds or basic training to do so (Carrasco, verbal testimony, 1993). In Texas, if the death of a child younger than age 18 is unexpected, the law requires an autopsy, but a justice of the peace, who may need only be a high school graduate, makes the critical decision on whether the death was unexpected (Evans, verbal testimony, 1994).

This outmoded approach to certifying death has led to problems such as local coroners who refuse to consider abuse as a cause of death because "the parents seemed like such nice people" or "they had an unusually clumsy child," as experts testified before this Board in 1993 and 1994. As a result of these intertwined problems of undertraining and personal reluctance, hundreds, and perhaps thousands, of children die each year from abuse and neglect only to have their deaths misidentified by coroners and medical examiners as being due to natural, accidental, or undetermined causes. Indeed, Child Death Review Teams often find themselves probing issues that a qualified coroner or medical examiner could have already fully addressed.

"the parents seemed like such nice people"

Police Often Are Not Trained to Detect or Deal With Serious and Fatal Child Abuse

Homicide detectives investigate a child's death only when it appears that the death may have been at the hands of another. However, their expertise is usually limited to what they know from investigating adult homicides. Unlike most child fatalities, the unnatural death of an adult is often obvious, and detectives quickly focus on who committed the crime—not on determining whether a crime has even occurred.

If police focus on children involved in domestic violence, child abuse could more effectively be identified.

Retrospective reviews of child fatality cases have discovered too many instances where police had contact with abusive parents or caretakers, but for many reasons failed to assure the child's safety. If investigating police focused on children in families involved in domestic violence and drug abuse, child abuse could more effectively be identified and reported (Minnesota State Department of Human Services, 1991). In addition, the police sometimes fail to identify children who show signs of

"The clock starts when a child's death is noted to be suspicious. Law enforcement should be involved and have begun the case evaluation, death scene evaluation, and cleared criminal justice, and CPS records, all within 2 hours."—Capt. John Welter, San Diego Police Department, Los Angeles Focus Group, 1994

neglect, such as being underweight, dehydrated, or in need of medical care. Saving an infant or small child could be as simple as "looking under their shirt or blanket" before leaving the home, as several experts testified.

There have been a number of improvements within some police agencies recently. The Los Angeles County Sheriff, for example, now requires that investigating officers view the bodies of all living children who are reported to be victims of alleged physical abuse. The policy was instituted in 1992 in response to a case in which a preschooler died after deputies responded to an abuse complaint, but did not look at the child's body as he "slept" under a blanket. Had the deputies looked, they would have discovered extensive injuries to the boy's legs, torso, and arms from being tied down. During Child Death Review Team meetings, Los Angeles City police shared their protocol for inspecting children's bodies, which was soon replicated by the Sheriff's Department. This protocol is now part of the State's Peace Officer Standards and Training.

In addition, Dallas and some other cities now use officers specifically trained in abuse and neglect issues to investigate child fatalities and have created "family violence units" that respond both to child abuse and domestic violence complaints. Because it is critical that police coordinate with other agencies, Dallas CPS workers and child fatality detectives are housed in the same building and respond to deaths in teams. In Des Moines, Iowa, the impetus has come not from the police but from the city's Pediatric Trauma Team, which assures that there is an immediate response to all reports of serious and fatal child abuse by police, juvenile courts and CPS investigators 24 hours per day. However, most improvements in investigation are recent, and no data are available to determine their impact on child deaths from abuse or neglect.

Child Protection Workers Are Often Inexperienced, Undertrained, or Overextended

The NCPCA estimates that about 42 percent of the children who died have had previous or current contact with a CPS agency. Other studies found prior CPS contact with 30 to 45 percent of families in which a fatality occurred. The "prior contact" figure ranges from 17 percent in Colorado to 63 percent in San Diego (McCurdy & Daro, 1988).

The current system is susceptible to too many human errors and flaws. These problems arise from the recent history of child welfare, which has rapidly changed from role of "helper" or "counselor" to "investigator" in order to respond to the burgeoning crises of family violence and family breakdown. Governments have neither consciously acknowledged the cultural changes required within CPS agencies nor addressed the professional training required to make these changes. In some States, child protection workers receive little training to determine the cause of a child's injuries before they result in death or to detect clues that might indicate that a child is in danger.

"It is incongruent and unreasonable to continue to expect poorly trained, low-paid staff to appropriately assess the needs of children and their families."—Megan E. McLaughlin, D.S.W., Federation of Protestant Welfare Agencies, New York Public hearing, 1994

Even well-trained workers cannot function adequately with unmanageable caseloads. While some regions and States do much better than others, in many jurisdictions caseloads are so high that the best CPS can do is take the complaint call, make a single visit to the home, and decide whether the complaint is founded or unfounded. Often, there is no subsequent monitoring of the family.

For example, CPS in New York has reached a saturation point, according to James Cameron, Executive Director, New York State Chapter of the NCPCA (verbal testimony, 1994). In New York, CPS agencies receive over one hot-line call per minute from relatives, neighbors, friends and professionals reporting suspected cases of abuse or neglect. Leah

Harrison (1994), of the Child Protection Center of Montefiore Medical Center in New York, testified that the Center works with the local child welfare agency to protect children. She has found that the agency's staff is unaware of the implications of many medical diagnoses and sometimes makes decisions based on their rules and regulations without taking into consideration the implications of their decisions. Moreover, according to Harrison, many caseworkers lack the resources needed to create an appropriate service plan for the family to ensure a child's safety.

New York is hardly alone. In many cities and States, a litany of child abuse and neglect tragedies have resulted in lawsuits and highly negative press coverage and have created the appearance of widespread professional incompetence. Nevertheless, this Board believes it is a mistake for the public to hold CPS agencies solely responsible for these failures to save children. Placing such a large burden on a single, beleaguered agency is akin to expecting school truancy officers to identify and resolve the complex and persisting problem of urban street gangs.

Multiple Problems Deter the Prosecution of Perpetrators

ONE RECENT CASE:

An Oklahoma mother asked her boyfriend to babysit for her infant girl. While she was gone, the boyfriend became enraged over the baby's crying and violently shook the child until the infant was dead. An autopsy revealed severe brain damage caused by shaking. After the boyfriend's arrest, a photograph of him ran in local newspapers showing him wearing a bill cap popular in Oklahoma that read, "Number One Dad." At his trial, the man admitted he had attacked the child, but the jury found him not guilty. Later, the district attorney (D.A.) was criticized for charging the boyfriend with first-degree murder, since the jury was not able to accept the killing as premeditated.—Barbara Bonner, Verbal testimony, New York focus group, 1994.

Most prosecutors are not specially trained to prosecute child homicides by abuse or neglect. Specialized training and vertical prosecution, in which one attorney carries a case from referral to disposition, are now common in cases of sex crimes against children, but not in cases of child homicides, including fatalities from abuse or neglect.

In addition, judges at all levels have inadequate knowledge about child maltreatment-related fatalities, and too often they are not provided with critical information regarding family history before they impose sentences. Consequently, judges often agree with prosecutors that child homicide defendants should be allowed to plead to lesser crimes. Prosecutors suggest lesser pleas for several reasons: the investigation has failed to provide sufficient evidence to prove the charges beyond a reasonable doubt; the prosecutor lacks the knowledge on how to prove the charges; or there is an absence of a felony murder statute with which to charge the accused for the child's death.

"Prosecutors all over the country will tell you that the easiest murder to get away with is the killing of an infant or small child by a parent or caretaker."—J. Tom Morgan, Atlanta D.A. and ABCAN board member, October 1994.

Prosecutors face major hurdles. Jury members often will not believe that parents and caretakers would seriously hurt or kill children, and the legal system often encounters spouses and relatives who side with perpetrators and delay or cripple investigations. In one Missouri case, the Jackson County prosecutor could not gather enough evidence on the death of a 4-year-old girl because so many of the family's adults had abused the child that no one could determine who inflicted the fatal blow. Surviving siblings and young cousins were threatened into silence and would not testify (Fincham, verbal testimony, 1994).

Despite these many obstacles to prosecution, there are some improvements underway. More perpetrators are being arrested and convicted with information gathered by Child Death Review Teams, the use of more and better autopsies, and extra efforts by concerned physicians. The National Center for Prosecution of Child Abuse deserves recognition for providing nationwide training and consultation for prosecutors in this area.

Yet much more must be done, and we will suggest strategies for change, including dramatically improved training of all front-line professionals, immediate-response joint criminal investigations, and adoption of statutes that allow prosecution of these crimes without the need to prove premeditation.

STRATEGIES FOR IMPROVEMENT: EXPANDING THE EXPERTISE

Broad New Training Efforts for All Front-Line Workers

CPS Training

With CPS increasingly consumed by investigations, CPS managers and line staff are now realizing that a graduate degree in social work alone does not prepare professionals to conduct such investigations and gather evidence related to criminal prosecutions. Some States are considering a dramatic shift that places police in charge of investigating serious cases and high-risk families, thus allowing both CPS and law enforcement to perform the tasks for which they are most skilled.

Some States, such as New Mexico and Connecticut, have enriched their CPS training programs in response to litigation. Alaska has designed and implemented mandatory, competency-based training for all child welfare and child protection workers.

Specialized training for CPS workers should prepare them to become knowledgeable members of Child Death Review Teams. This Board suggests a training model for CPS workers aimed at identifying and preventing serious and fatal abuse and neglect and helping workers assist other agencies in gathering child death investigation information. Such training should include:

- How to identify family strengths as well as risk factors associated with diverse groups and cultures. This would include how to identify normal child development markers via growth charts as well as markers for sufficient language development.

- Cross-training to relate better to other disciplines, with the aim of increasing cooperation among agencies, fostering greater awareness of clues to abuse, and sharing information on fatality cases.

- Training of, and with, community-based workers.
- Training and access to "user-friendly" automated client tracking and case management information systems that can greatly improve access to important information on a family or case.

Beyond training, one important, but problematic requirement must be keeping competent, highly trained people from leaving CPS due to burnout and stress. Low salaries exacerbate this problem. Regular consultation and inservice programs to minimize burnout, preparation for workers dealing with their own emotions after a case results in a fatality, and salaries commensurate with their responsibilities would do much to attract and retain good workers.

"What we need in those intervention and prevention stages is understanding from people like us. If somebody that's sitting next to me has not been through a bit of abuse, how are they going to recognize an abusive situation?"—A Woman from the Family Violence Program, Bedford Hills Correctional Facility, 1994

Medical Training

SHOWING THE WAY:

The University of Oklahoma Science Center is implementing voluntary interdisciplinary training for 180 doctors and other health professionals on child abuse and neglect fatalities. They will be taught how to recognize clinical signs of child abuse and neglect, informed of their obligation to report abuse, and encouraged to work with police and CPS.—Dr. Robert Block, Oklahoma Child Death Review Team, Dallas Public hearing, 1994.

Health care delivery settings, including public and private hospitals and clinics, health maintenance organizations, (HMO's), preferred provider organizations (PPO's) and special children's health programs should provide incentives and significant funding for the development and ongoing training of medical specialists in child abuse and neglect. This commitment should match training in other leading causes of death for children. Such an effort will require public health policymakers to understand the link between child abuse and subsequent lifetime medical, mental health, criminal, and educational costs of untreated and unrecognized child abuse.

ONE HOSPITAL'S EFFORTS:

Over the past 5 years, the Strong Critical Care Center at the University of Rochester Medical Center, in cooperation with a Child Death Review Team, has produced a series of papers identifying red flags for suspected child maltreatment-related deaths: inconsistent history compared with the physical examinations, history of drug or alcohol abuse, and past history of child abuse or previous involvement with the Department of Social Services. The red flags are now used to train medical staff to spot abuse cases. — Dr. Brahm Goldstein, Associate Professor of Pediatrics, University of Rochester School of Medicine, New York Focus group, 1994.

Increased Use of Immediate Response Joint Criminal Investigations

Joint criminal death investigations have existed at least since the time of Sherlock Holmes and Dr. Watson. For many years, physicians, law enforcement officials and others have informally collaborated to determine the cause and manner of human fatalities. Today, in response to systemwide weaknesses, some cities and counties are creating and training criminal investigation teams that immediately respond to questionable child deaths.

Joint criminal investigation teams differ from Child Death Review Teams in one critical aspect: their mission is law enforcement. They conduct criminal investigations of wrongdoing, rather than retrospective or prospective systemwide reviews of how the child's death happened or could have been prevented.

This Board believes that each team should include, at a minimum, a medical examiner, detective, a CPS caseworker, and a prosecutor.

Protocols should be developed with clear guidelines for the role of each team member from the moment a child's death or impending death is reported. Medical, CPS, criminal histories and other information must be freely shared among all involved.

Because of the hidden nature of many child deaths, the most effective joint criminal investigation teams conduct immediate-response death investigations for all children who die under suspicious circumstances. Prosecutors described to this Board the reluctance to share information between agencies and confusion over roles, problems that are often resolved or greatly decreased by the innovative aspects of team investigations.

"Our efforts have made borderline cases stronger, and strong cases unbeatable. And we ensure that those tragic child deaths that are accidental are accurately characterized as quickly as possible."—Lucinda Suarez, Special Victim's Bureau, Queens County District Attorney, New York Public hearing, 1994

For example, the Los Angeles Police Department's child abuse unit, composed of specially trained child abuse detectives, immediately sends a team to the scene of any suspected child abuse or neglect death. A team, including a prosecutor and coroner's investigator, interviews the parents, visits the hospital, and contacts CPS to determine over the phone whether the family has a history with the agency. The team has even sent the pathologist—day or night—to the death scene to review the child's injuries and witness the evidence. When the team's highly detailed and promptly collected evidence is presented in court, cases are usually prosecuted successfully (Smith, verbal testimony, 1994).

In Queens, New York, an immediate response criminal investigation team has taken the concept a step further, videotaping the death scene to be used as evidence. Such evidence has proved persuasive to juries. The videotape also prevents parents and caretakers from fabricating information or concealing evidence.

Despite these positive results, members of such teams also testified that the work hours are demanding, the pay is the same as colleagues who do not handle child death investigations, and the burnout level is high. For this reason, jurisdictions should provide incentives for child death investigation team members.

Suspected Child Abuse and Neglect Teams and Other Hospital Efforts

A growing number of hospitals are creating Suspected Child Abuse and Neglect (SCAN) teams responsible for evaluating, reporting, and treating child abuse and neglect and for providing consultation for other hospital staff and other agencies. The core teams include a physician, nurse, and social worker.

"Children are re-molested, re-abused and even die because an untrained medical practitioner, acting without benefit of a specialized SCAN team, did not recognize indicators of a serious or life-threatening injury. Conversely, many families are put through traumatic experiences when their children are inaccurately diagnosed as victims of abuse." —Dr. Astrid Heger, Director, Pediatric SCAN Team Los Angeles Focus group, 1994

SCAN teams build liaisons with law enforcement and fire department EMT's, which provide important contact with "first responders"—those who are first at the scene of a child trauma. Teams may also develop liaisons with home visiting professionals, including public health nurses. This broadens home intervention efforts and provides access to prior medical records from public hospitals and clinics.

Most hospitals do not have SCAN teams. Hospitals with such teams provide varying levels of service depending on whether their team offers primary care or acts as a referral center. We believe every child and family should have access to a "Center of Excellence" for tertiary referral in their region, staffed with trained experts to ensure accurate diagnosis and appropriate treatment. In rural areas, use of telemedicine techniques can enable any SCAN team to consult with a tertiary center hundreds of miles away.

Every child and family should have access to a "Center of Excellence"

AN IDEA THAT WORKS:

Bellevue Hospital's Child Protection Team is made up of representatives from pediatrics, court-appointed special advocates (CASA), substance abuse, and the psychiatric department. It reviews every trauma case admitted, including adult cases where a child is in the home, as well as all cases of domestic violence. Any Bellevue staff member who is unsure about a case may request team review. The team integrates its work with the D.A. The team routinely identifies cases of child abuse and neglect that are missed by hospital physicians and other health professionals.—Dr. Margaret McHugh, Director of Child Protection Team, Bellevue Hospital, New York Public hearing, 1994.

Mandated Autopsies

This Board heard strong agreement from professionals in many disciplines that the single most critical stage in determining the cause and manner of death of an infant or child is the autopsy. Yet here, in an area where the need for professional expertise is so obvious, the system fails dramatically. Few jurisdictions routinely perform autopsies when children die unexpectedly. Among the reasons given are:

- clear guidelines or regulations on when an autopsy should be performed;
- funds;
- competent medical examiner;
- political system in which an elected official decides if an autopsy is needed;
- religious prohibitions both actual and claimed;
- personal reluctance, especially among coroners who may know the family.

Some States and regions are showing the way in this extremely critical area. As of 1992, Kansas appeared to be alone in requiring autopsies of all children who die under suspicious circumstances or of unknown causes (National Center for the Prosecution of Child Abuse, 1994). Georgia requires autopsies of all children age 7 and under, a law which sufficiently captures the high-risk age groups. Curiously, child autopsies have been mandated in the past 5 years in Maine, Nebraska, Oklahoma, Illinois, Iowa, Ohio and Missouri in response to public concern; but, depending on the State, these mandates exclude children who die after age 3, age 2, or age 1 (National Center for the Prosecution of Child Abuse, 1994). Thus most State autopsy mandates do not apply to many children who die from abuse or neglect.

Some localities have chosen to be far more inclusive without waiting for State mandates. For instance, Tarrant County, Texas, (Fort Worth) has adopted a policy requiring that all children who die under the age of 15 be completely autopsied, with microscopy and comprehensive toxicology studies (Peerwani, verbal testimony, 1994). Oregon's medical examiner system reviews all unexplained deaths within 24 hours, and most autopsies are performed by board-certified forensic pathologists (Lewman, verbal testimony, 1994). Missouri provides its Child Death Review Teams with a Certified Child-Death Pathologist Network. Mary Case, Chief Medical Examiner, St. Louis County, notes that prosecutors in Missouri are far more willing to pursue cases because forensic pathologists are much better at presenting evidence to a jury, and attorneys are far more educated about the nature of maltreatment fatalities (verbal testimony, 1994).

"The attitude of rural deputy prosecuting attorneys is that child protection cases are just 'kiddy' cases."—Ed Vandusen, Program Manager, Division of Family and Children's Services, Idaho Dept. of Health and Welfare, Oregon public hearing, 1993

Enhanced Prosecution and Evidence Gathering

Murder is no less a crime because a child, rather than an adult, is the victim.

Murder is no less a crime because a child, rather than an adult, is the victim. Only 21 States have either legislatively delineated child abuse as an underlying felony contributing to felony murder or enacted homicide by child abuse statutes (Rainey, personal communication, 1995). In States without such legislative intent, felony murder charges may not be possible.

Felony murder statutes allow juries to return a verdict of guilty when the prosecutor has proved beyond a reasonable doubt that the defendant intended to commit a felony (i.e., child abuse) which resulted in the homicide. If a defendant is shown to have intended to commit felony child abuse, the defendant may be convicted of murder if the child dies. Elements of the murder such as malice aforethought, premeditation, and intent to kill—which are difficult to prove in child homicide—are not required.

Jurisdictions that have adopted felony child murder or equally effective "homicide by child abuse" laws have experienced increased convictions when prosecuting perpetrators. For example, Oregon differs from the Nation as a whole in that it has a higher rate of criminal prosecution of fatal child abuse cases (approximately 68 percent). "It is possible that Oregon's prosecution rate is higher due to a murder by an abuse statute that passed in 1989. This statute enables prosecutors to charge an alleged offender for a crime that specifically addresses the dynamics often present in child death without requiring proof of intent to murder, a condition seldom provable in child abuse fatalities" (Oregon Department of Human Services, 1993, p. 4). Children in every State deserve a similar level of justice.

CHAPTER TWO RECOMMENDATIONS

This Board has identified a critical need to better educate professionals to identify and respond to fatal child abuse and neglect and to hold perpetrators responsible for their actions. Without a greater understanding among police, physicians, CPS workers, coroners, prosecutors, mandated reporters, and others about the circumstances, red flags, subtleties, systemic problems, attitudes, and obstacles that characterize fatal abuse and neglect cases, innocent children will continue to fall through the cracks in the system. Moreover, if society fails to communicate to parents that child abuse and neglect fatalities must receive the same level of justice as adult homicides, a tacit and dangerous message is sent that such deaths are more acceptable and carry less severe consequences. We therefore recommend:

Recommendation 3: The supply of professionals qualified to identify and investigate child abuse and neglect fatalities should be increased.

The leadership of DHHS and the Department of Justice (DOJ) should work with professional associations to develop a national strategy to address the dramatic lack of medical, law enforcement, and legal and social service professionals qualified to identify and investigate child abuse and neglect fatalities. This effort should focus on:

- Recruitment and training of more practitioners by offering scholarships or loan forgiveness.

- A review by each discipline of projected training patterns to determine if it can produce enough experts. Each discipline should promote ways to increase expertise via development of continuing education, improvements in school curricula requirements, and inservice training.

- Increasing medical expertise, in particular. This goal should be addressed by the American Medical Association (AMA), National Association of Medical Examiners (NAME), AAP, American Public Health Association (APHA), and others, working cooperatively with

States should include development of: competent forensic medical examiners in every State; training of medical examiners who specialize in pediatric pathology; creation by National Institutes of Health (NIH) of funded medical fellowships in forensic pediatrics as well as forensic pathology, pediatric radiology, and public health/child abuse; enactment by States of a requirement that any doctor in pediatrics, emergency medicine, or family practice complete child abuse training within a short time of licensure; and creation of a study section for child abuse within the NIH.

Recommendation 4: There must be a major enhancement of joint training by government agencies and professional organizations on the identification and investigation of serious and fatal child abuse and neglect.

The Secretary of Health and Human Services and the U.S. Attorney General should utilize funds to improve multidisciplinary training in all disciplines charged with identifying and investigating child abuse and neglect fatalities, with an emphasis on crosstraining where possible. This effort should be tailored to a broad audience including child welfare workers, law enforcement officers, prosecutors, mental health practitioners, physicians, paramedics, EMTs, and others who might work in a front-line capacity.

Regular training should be provided by the National Center for Prosecution of Child Abuse, AAP, NAME, AMA, Society for Pediatric Radiology, American Hospital Association, American Professional Society on the Abuse of Children, American Public Welfare Association, APHA, the Association for Death Education & Counseling, Association of SIDS Program Professionals, National Association of Children's Hospitals & Related Institutions, National Association of Social Workers, National Fetal Infant Mortality Review Program, the National Council of Juvenile and Family Court Judges, the International Association of Chiefs of Police, the International Homicide Investigator's Association, Peace Officer Standards and Training Board, and NCPCA.

Finally, the National District Attorneys Association should develop, with the AMA, joint training for all professionals involved in the identification, investigation, and prosecution of fatalities.

Recommendation 5: States, military branches, and Indian Nations should implement joint criminal investigation teams in cases of fatal child abuse and neglect.

All States should create criminal investigation teams either at the local or regional level to investigate any "unexpected child death," as previously defined in this report. The Department of Defense should create teams for the military branches. Indian Nations, DOJ, and Indian Health Service should ensure that such teams operate to review deaths in Indian Country. Each team should, at minimum, include a medical examiner or coroner, law enforcement officer (preferably a child abuse or homicide detective), child protection worker and prosecutor, who work under a protocol that clearly defines each role and allows for effective, confidential sharing of medical, family and criminal histories.

Recommendation 6: States and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) should adopt requirements to assure all hospitals with pediatric services have SCAN teams.

Any hospital with a pediatric unit should be required by the state, military branch, Federal agency, or Indian Nation that oversees its certification to have a SCAN team, including a physician, social worker, and nurse specially trained to evaluate, treat, report, and consult on child abuse or neglect cases. The JCAHO should adopt this requirement. Such teams should interact with investigators and other agencies on abuse/neglect and suspicious injury cases involving children.

Recommendation 7: All States should enact legislation establishing child autopsy protocols. Federal funding for autopsies of children who die unexpectedly should be available under the Medicaid program.

Autopsies should be required, at a minimum, when any child's death is suspected by investigators as being a homicide, suicide, the child was not under supervision of medical personnel at time of death, or the cause of death is not readily determinable. In addition, no cause of a child's death should ever be listed as SIDS without an autopsy, death scene investigation, and clinical review. Such autopsies are also in the interest of parents of SIDS infants, who suffer doubt when an infant dies suddenly and unexpectedly. To implement this effort, Federal funding for autopsies should be an option under the Medicaid program.

Recommendation 8: States should take steps to ensure that all children have access to available, necessary medical care when they are at risk of serious injury or death.

- Laws protecting children must be applied equally and fairly. All States should ensure that civil child abuse laws include the provision that the failure of parents to provide medical care, when such care is available and necessary to protect a child from death or serious harm, is reportable under the State child abuse and neglect reporting law, regardless of the religious beliefs or practice of the parents. State child abuse reporting laws should not differentiate the handling of possible medical neglect cases based upon the parent's religious beliefs.

- State courts must retain clear authority to order necessary medical care when parents and others, legally responsible for providing medical care, fail to provide it.

- Decisions regarding prosecution of parents who fail to provide available, necessary medical care for their children should be made within each State.

- States should ensure that all health care providers—including spiritual healers who provide health care for payment through public or private insurance reimbursement—are listed as mandatory reporters of child abuse and neglect, thereby involving such providers in training activities that are conducted for mandatory reporters.

Recommendation 9: States should enact "felony murder or homicide by child abuse" statutes for child abuse and neglect. States that currently define child abuse as a misdemeanor should establish laws to define child abuse and neglect as felonies.

Felony murder statutes should specifically include child abuse or neglect felonies as one of the underlying felonies, as in 21 States currently. In some States, an alternate but equally effective law may be "homicide by child abuse or neglect."

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"Who killed Cock Robin?...
Not I certainly says the fly;
My dear, this polyhedral eye
Can only make things out nearby
I mind my own bee's wax;
that's my Alibi"
W.D. Snodgrass
Coroner's Inquest

CHAPTER THREE

THE NEED FOR A NATIONWIDE SYSTEM OF CHILD DEATH REVIEW TEAMS

In the previous two chapters we have described the dimensions of fatal abuse and neglect that will, in the 1990s alone, take the lives of thousands of infants and small children who are alive today or yet to be born. We have also detailed our society's patchwork system of inadequate efforts to identify, investigate, and understand these tragedies and to prosecute the perpetrators.

This Board has concluded that child abuse and neglect fatalities and serious injuries cannot be significantly reduced or prevented without more complete information about why these deaths occur and how such tragedies might be avoided. Despite instance after instance of system breakdown, inadequate response, and misplaced effort described in testimony during 1993 and 1994, we also heard agreement from scholars, professionals, and officials that a system of comprehensive Child Death Review Teams can make a major difference.

It is important that we make clear that this growing national movement to understand and reduce child abuse and neglect deaths is not, as some may believe, a "low payoff" pursuit, particularly in a country such as ours. The United States has long been committed to improving the quality of life of its citizens, expending years of strenuous and costly effort to save modest numbers of lives by changing risky or inappropriate human behavior.

It took decades of high-profile public awareness campaigns, regulatory pressure on car makers, gradually toughened drunk-driving laws, and the lowering of highway speed limits to reduce U.S. motor vehicle deaths from 23.1 per 100,000 in 1963 to 16.3 per 100,000 in 1993, amounting to 1,564 fewer lives lost in 1993 over 1963 (Bureau of the Census, 1993; National Safety Council, 1994). And it took years of public awareness campaigns, increasingly stringent regulations, and stronger union demands on safety conditions to reduce on-the-job fatalities from 12 per 100,000 workers in 1984 to 8 per 100,000 in 1993, representing 2,600 fewer lives lost per year (National Safety Council, 1994).

"Teams have to perform not just a medical autopsy but literally a social autopsy on that family to determine what led to that child's death."— Dr. William L. Kincaid, Acting Director of Health and Hospitals, City of St. Louis, St. Louis Public hearing, 1994

Our message is that we, as a society, have always pursued avenues that we hope will reduce untimely deaths, even if it takes 30 years to make major inroads, and even if a decade is too brief a time to declare success. This Board believes that, if a long overdue national commitment is finally made, we will over time see a significant reduction in child deaths, disabilities, and severe injuries from abuse and neglect.

The formation of Child Death Review Teams in all jurisdictions is important to achieving this goal. Just as with other efforts to reduce fatalities and severe injuries, measurable results will not be immediately apparent. In fact, it is our prediction that, in the first few years after Child Death Review Teams are adopted in each area, the known number of abuse and neglect deaths will dramatically increase as we become better at investigating and accurately identifying such deaths.

THE HISTORY OF CHILD DEATH REVIEW TEAMS

The first large-scale, systematic Child Death Review Team comprised of criminal justice, health, and social service professionals was created in Los Angeles County in 1978 by Dr. Michael Durfee, a California child psychiatrist who was frustrated by the failure of law enforcement, medical, or child protection systems to determine why hundreds of Los Angeles-area infants and small children were dying under often vague and violent circumstances. Under the auspices of the Inter-Agency Council on Child Abuse and Neglect (ICAN), a multidisciplinary group from several agencies gathered to review deaths which seemed potentially related to abuse or neglect. The team discovered many abuse and neglect deaths that had been missed. It suggested improvements to make agencies more accountable, helped increase prosecutions, and promoted ideas to improve services and treatments for high-risk families (Durfee et al, 1992).

The first systematic Child Death Review Team was created in Los Angeles County in 1978.

Slowly, the ideas from Los Angeles County were adopted in a handful of other areas. Then, in the late 1980's and early 1990's, as a result of a grassroots movement fueled by efforts of earlier teams, cooperation from public agencies, and the increasing numbers of other multidisciplinary child abuse teams that shared resources and provided information and support, Child Death Review Teams began to proliferate, all with the same basic goal: to understand and prevent child deaths.

According to the American Bar Association (ABA), eight States passed statutes for Child Death Review Teams in 1992 alone (Robinson & Stevens 1992). Today, the early efforts undertaken by Dr. Durfee are being replicated in many communities, from quiet Missouri towns to Colorado mountain resorts to large Eastern cities, as recognition spreads that the teams can fill a great unmet need.

Eight states passed statutes for Child Death Review Teams in 1992 alone.

The Child Death Review Team phenomenon is still so new and evolving that much of the public and national media are not aware of the very existence of the teams. Nevertheless, dozens of experts testifying before this Board in 1993 and 1994 agreed that well-designed, properly organized Child Death Review Teams appear to offer the greatest hope for defining the underlying causes and scope of fatalities from child abuse and neglect, identifying child protection system weaknesses, and for determining future avenues for prevention and treatment.

A RICH SOURCE FOR UNDERSTANDING

Already, Child Death Review Teams have become one of our richest sources for understanding the factors surrounding the untimely deaths of children. Currently 45 States have local and/or statewide Child Death Review teams. It was partly through Child Death Review Team findings, in the form of annual reports by teams in California, Oregon, Colorado, Missouri, Ohio, Oklahoma, Vermont, South Carolina, North Carolina, Arizona, and elsewhere that important information came to light on the very young age of most victims, evidence of previous agency involvement with many families, demographic data on income and ethnicity, and profiles of individual perpetrators (ICAN, 1994; Oregon Department of Human Resources, 1993; Colorado Child Fatality Review Committee, 1993; Stangler & Kivlahan, 1993; Missouri Department of Social Services, 1993; Schirner & Griggs, 1992; Vermont Child Review Committee, 1991; South Carolina Department of Human Resources, 1993; Brown & Cox, 1994; Arizona Department of Health Services, 1994).

Currently 45 States have local and/or statewide Child Death Review Teams.

On a regular basis, teams grapple with systemwide flaws and outmoded policies that often prevent authorities from recognizing and properly responding to the deaths of infants and small children due to abuse and neglect. Thus, the teams are in an ideal position to recommend reforms and innovations that, it is hoped, will one day save children's lives.

Some States, such as Missouri, Colorado, and California, have highly effective local and State teams that are already making a difference. In Los Angeles County, for instance, as a direct result of the collaborative efforts of team review and improved criminal investigations, the percentage of child abuse and neglect homicides presented to the district attorney (D.A.) grew from 50 percent of child abuse and neglect homicides in 1989 to 87 percent in 1992. The percentage of cases in which murder charges were filed by the D.A. increased from 78 percent in 1989 to 100 percent in 1992 (ICAN, 1993).

In response to review team findings of abuse and neglect fatalities missed by the system in Colorado, the death certificate has been substantially revised and a 1992 law gives coroners access to child protective service (CPS) records when investigating questionable child deaths.

"Now that the teams have scrutinized all children's deaths in Colorado, we see clearly the numbers of children who have died needlessly, brutally, or in circumstances of gross neglect. Out of this wasteland must come some meaning."—Dr. Donna Rosenberg, Pediatrician, Denver Public hearing, 1993

In Georgia, the first State effort to review child deaths was undertaken in 1989 in response to a newspaper exposé on suspicious child fatalities by the *Atlanta Journal-Constitution.* The State review unveiled so many hidden instances of fatal abuse and neglect that Georgia mandated a system of local Child Death Review Teams and reformed the State's old-fashioned elected coroner system. Coroners had often misdiagnosed—and in some cases had even helped to cover up—all but the most obvious child abuse and neglect deaths. Today, a full medical examiner's inquiry is required for any unexpected or unexplained death of a child under age 7.

In Iowa, Child Death Review Teams successfully promoted a new rule for handling disputes among physicians over whether a child has been abused—an issue of great importance in deciding whether a child can safely be returned home. If two doctors disagree, the decision is taken out of the hands of the CPS case worker and made by a third, mutually acceptable physician, or by a physician with greater expertise.

Well-organized local efforts have also produced impressive results. One team with a well-developed review procedure is the Franklin County, Ohio, Deceased Child Review System, which now works with hospitals and health authorities to identify postpartum mothers who are at high risk for abuse and neglect and immediately links them with services.

Well-organized teams have produced impressive results.

In Los Angeles, the countywide team discovered during case review that many males involved in fatal child abuse were boyfriends or former partners of the mother who did not live in the home, yet were allowed to babysit. The Director of Children and Family Services subsequently alerted all CPS workers to evaluate the caretaking abilities of each family's babysitters as an integral part of assessing risk to children in the home.

Teams have proven valuable in efforts to reform the flawed system for collecting and analyzing data on child abuse and neglect deaths described in Chapter One. Arizona, California, Colorado, Missouri, Oklahoma, and others have developed comprehensive data forms for recording each child fatality by demographics, medical history, previous CPS contact, and other factors important to improving services and creating prevention strategies.

While teams may initially focus their efforts on the most extreme cases of abuse and neglect, and upon deaths whose causes seem suspicious or vague, over time most teams expand their focus to include review of all child deaths. Many teams have identified trends in child deaths due to accidents and other causes, leading to the development of preventive actions.

For example Child Death Review Teams have promoted many laws and agency-level policy improvements aimed at reducing child death caused by so-called "supervision neglect," such as swimming-pool drownings and tragedies involving children playing with guns. California, Florida, and Minnesota, for instance, now hold parents responsible if a child injures or kills himself or someone else with a family gun left accessible to the child.

Other teams have been equally successful. A team in Sacramento coauthored regulations for backyard pool fencing following a rash of child drownings, and a team in Placer County, California, undertook an education campaign with doctors and parents after several toddlers drowned in small tubs and 5-gallon buckets. A team in Franklin County, Ohio launched a program assuring that all families with young children were issued smoke alarms, and a team in Oregon developed a Relief Nursery Program for parents at high risk for abuse. The Los Angeles County team joined several State Attorneys General in petitioning the Food and Drug Administration (FDA) to child-proof the packaging of prenatal iron tablets and change the coloring to make them look less like candy. This action followed the poisoning deaths of 12 infants and small children in Los Angeles County who swallowed handfuls of the tablets while unsupervised. In October 1994, the FDA published proposed regulations to implement the changes.

As the teams continue to spread to new areas, it is hoped they will gather enough information to guide society as it designs a new generation of prevention efforts. They will have even greater influence, using what they know to draw a more detailed picture of the families and situations involved in severe and fatal child abuse. This Board believes that such efforts can provide direction to child abuse and neglect prevention and treatment services, and one day dramatically reduce the unacceptable rates of child abuse and neglect fatalities in the Nation.

A RECENT CASE:

A sheriff's deputy in a California suburb thought there was something familiar about her latest case, that of a seriously injured little boy. Then she remembered that the same babysitter had been watching baby girl Jennifer, a 7-month-old who had died 2 years earlier from a massive subdural hematoma. After Jennifer's death, a fellow deputy had asked the Child Death Review Team for help because she sensed that neither parent had killed Jennifer. The Review Team found that Jennifer died from a blow to her head equal to a direct hit with an iron frying pan. They pinpointed the time of the attack to the period in which the babysitter was watching Jennifer. Unfortunately, the babysitter disappeared. Two years later, the quick-thinking deputy, investigating the serious abuse of another young child, and armed with information from an effective Child Death Review Team, remembered the same babysitter and arrested her for Jennifer's murder.—Deanne Tilton Durfee, Written testimony, Los Angeles, 1994

ONE COOPERATIVE SUCCESS:

Team investigations and prosecutions are being successfully used by the Bridge Child Advocacy Center in Texas to increase the prosecution and conviction rate of perpetrators of child abuse and neglect. With this new cooperation, the prosecution and conviction rate has increased from 35 to 90 percent for homicide/felony murder.—James Farren, J.D., Assistant District Attorney, Potter County, Texas, Dallas Public hearing, 1994

A TEAM SENDS A MESSAGE:

The team in Multnomah County, Oregon, reviews all cases of child abuse and neglect in the county. Based on what the team learned, Multnomah County created "red flag" protocols to help CPS identify high-risk cases and increase review of families in which children may be in danger. These red flag protocols are being integrated in child welfare system policies statewide.—Helen Smith, Deputy District Attorney, Multnomah County, Oregon, Oregon Public Hearing, 1994

HOW TEAMS OPERATE

Local Teams

Unlike criminal investigation teams described in Chapter Two, the primary goal of Child Death Review Teams is not to find and bring a perpetrator to justice. The Review Teams determine the circumstances surrounding a child's death and recommend appropriate follow up. They track the system's response to the child's death and recommend ways to protect and serve surviving siblings; improve the procedures and accountability of the child protection, law enforcement, and public health systems; and reduce future child deaths.

"As the team reviews the moments, days, and months preceding the death of a child at the hands of a caretaker, an overwhelming sense of loss, failure, and anger is inevitable."— Deanne Tilton Durfee, Chairperson, ABCAN, Director of ICAN, Los Angeles, July 1994

Local teams tend to be more investigatory than statewide teams, which usually act as reviewers of aggregate information on child death. In order to perform well, local teams must be diverse, expert, and granted broad access to information.

Local teams often review the same cases that detectives are investigating. They focus on obvious abuse and neglect fatalities and suspicious deaths to ensure that police and medical authorities do not overlook such deaths, as so often happens. Teams may work closely with a local prosecutor, creating a multidisciplinary, multiagency effort that serves a case-building function. The composition of local teams often includes the coroner or medical examiner, prosecutor, law enforcement, medical representative, CPS staff, and others on an as-needed basis.

However, local Child Death Review Teams range in size, composition, types of deaths reviewed, purpose, and effectiveness. Some urban areas, such as New York City, use a case-review process controlled by a single CPS agency that reviews only its own cases. Such teams miss significant numbers of deaths in their regions, since less than half of child abuse and neglect deaths occur in families known to official CPS agencies.

Single-agency reviews also lack the accountability of systemwide, multiagency peer review.

The makeup and expertise of local teams vary considerably from rural to urban areas. The definitions and the kinds of information collected differ, creating barriers to compiling a complete nationwide picture.

FROM THE TRENCHES:

Since the death review process was first attempted in Idaho in 1989, team members have encountered resistance from local law enforcement and judicial personnel who do not want to work on child abuse and neglect cases. Local agencies lack the resources and personnel to counteract problems created by misunderstood confidentiality regulations and county coroner systems that rely on coroners with little or no medical training. — Ed Vandusen, Division of Family and Children's Services, Idaho Department of Health and Welfare, Oregon Public Hearing, 1994.

Statewide Teams

The epidemiological approach of well-designed statewide Child Death Review Teams is invaluable. They collect larger samples of cases than local teams, allowing them to detect trends and view information with a perspective that is not always obvious in local analysis. Today, 31 States have statewide teams. In addition, the District of Columbia and the Department of Defense have teams for all its military branches. However, 14 States still have only local teams, often serving just one major city, and 5 States have no team of any kind at the time of this publication.

Statewide teams usually meet periodically for retrospective reviews that can include a backlog of months or years of cases. They may review deaths from abuse and neglect as well as other suspicious deaths. Because of the large number of deaths reviewed and the difficult logistics of assembling a State team, they generally are not designed to offer investigative assistance or to help access services for surviving family members.

State teams usually have a diverse composition, often including individual experts, government officials, and agency representatives. Officials from the state Departments of Public Health, Social Services, and Attorney General's office may be part of a larger team that includes members from education, pediatrics, forensic pathology, child psychiatry, mental health, social services, and nursing. The members may provide expertise on substance abuse, domestic violence, Sudden Infant Death Syndrome (SIDS), perinatal mortality, suicide prevention, child advocacy, religious issues and other fields. This interaction can promote significant improvement across many agencies and disciplines.

State government involvement in designing and implementing teams varies. Colorado and Oregon have statewide committees that actively function as both case-level and retrospective review teams, while California's and Missouri's State panels monitor and assist county review teams.

ONE STATE'S STRUGGLE:

In Houston, a lack of funding or incentives creates burnout and turnover on the local team. Often the team doesn't have the personnel or time to collect and review all pending child death cases. Complicating matters, largely unfounded fears about confidentiality between agencies cause a great deal of confusion and missed opportunities in investigating and prosecuting abuse cases.—Denise Oncken, J.D. Assistant District Attorney, Chief of Child Abuse Division, Harris County, Texas, Dallas Public hearing, 1994.

However, resistance to and underutilization of statewide teams present problems. Politics and individual reluctance have prevented or delayed the formation of review teams. Populous States such as Michigan, Florida, Ohio, and Virginia have lagged behind. Other populous States, such as New York and Pennsylvania, are just now launching state teams.

Increasingly, areas with poorly designed teams, or no teams, will find themselves left behind as other areas begin to understand basic systemic problems and move to implement reforms designed to protect children. States with less intensive or no review team efforts have little idea of the extent of child abuse in their areas.

For example, Missouri (population 5.1 million) found more than 40 child abuse and neglect deaths in both 1992 and 1993 using its extensive child death review system, but Michigan, a state with almost twice as many people (population 9.3 million), has never reported more than 19 abuse or neglect deaths—a highly unlikely figure. Similarly, Colorado (population 3.3 million) has used its effective State review team to reveal about 30 deaths per year from abuse and neglect, while Kansas (population 2.5 million), a State that lacks comprehensive review, could find only 6 such deaths in 1993 or 1994 (McCurdy & Daro, 1994; U.S. Census, 1990).

Fatal abuse and neglect ranks with annual deaths of teenage gunfire victims.

While these raw numbers for fatal abuse and neglect may appear small when broken down to a State level, they in fact rank with annual deaths of teenage gunfire victims (Bureau of the Census, 1993) and motor vehicle deaths of children age 15 and under (Children's Safety Network, 1994).

One State's Experience:

When Oregon's State team discovered a high rate of fatalities involving Shaken Baby Syndrome, a public awareness campaign was launched on the dangers of shaking babies. The team sought improvements in protocols of State welfare agencies, which now obtain more background on families involved in all child abuse and neglect cases. They give cases involving infants and preschool children a higher priority and assign difficult cases only to experienced CPS staff.—Connie Gallagher, Program Development Manager, Children's Services Division, and Co-Chair of Oregon's Child Fatality Review Team, Oregon Public hearing, 1994.

STATE OF THE ART MODELS

Many experienced local teams and comprehensive State teams have identified far more cases of child maltreatment-related deaths than previously determined by the old system; they have also discovered patterns that led up to these deaths. Effective teams have begun to press for new policies and increased awareness aimed at protecting children. Missouri, Colorado, and California offer three dramatic examples of how competent, multidisciplinary, multiagency review can significantly change what we know about child abuse and neglect deaths. They are described below.

The Missouri Model

In 1992, Missouri enacted a visionary law creating a child death review system that requires all 115 counties to have teams that include a prosecutor, Division of Family Services official, medical examiner or coroner, and others. A statewide team was given policy-level responsibilities, while county-level teams conduct case-by-case review within 48 hours of the death of any child younger than age 15. All local teams include individuals already mandated to investigate a particular case, such as police officers, juvenile officers, or Department of Family Services workers. The law was the result of efforts by a handful of frustrated and highly motivated individuals in leadership positions who saw a need and addressed it.

Under Missouri law, extensive data collection is mandated. Review teams must complete a standardized data form, for every death of a child age 15 years or younger. All deaths are initially reviewed by the coroner or medical examiner, and if certain characteristics are present, such as a lack of witnesses or explanation for the death, the case must be reviewed by the entire team. In order to counteract the reliance upon coroners, who, unlike medical examiners, may have no medical training, the chairman of the review team must agree that the coroner is correct in deciding that a case is not reviewable.

Since the Missouri team began its effort, 35 percent of all child deaths under age 15 have been found to require review. Investigators confirmed a startling 84 percent more child deaths from abuse and neglect in 1992 than the traditional system found in 1989 (Stangler & Kivlahan, 1993).

The Missouri team confirmed a startling 84 percent more child deaths from abuse and neglect in 1992 than in 1989.

Work by the teams has directly affected the outcome of numerous investigations by child protection and law enforcement agencies because social workers and police on the review team routinely get information they would not otherwise learn, either from each other or from the pathologist, who often provides new witnesses and followup information. Officials believe they are counting and determining the accurate cause of death for virtually all young children in Missouri, a unique and major achievement.

The Colorado Model

The Colorado Child Fatality Review Committee investigates risk factors; evaluates services and system response to children and families considered to be at high risk for any type of fatality; develops findings that can be addressed by public policy; and improves information via autopsy reviews, death investigations, and death certificates (Thigpen & Bonner, 1994).

Unlike Missouri's legislative mandate, the Colorado Committee was created by an agreement between the State Department of Health Services and Social Services, and includes representatives from those Departments, as well as Education, Transportation, and Criminal Justice, along with community experts who together review cases and issue an annual report.

As a result of the Committee's work, Colorado has passed legislation to improve exchange of records among professionals working on child death cases; developed death scene investigation guidelines for police, coroners and CPS; revised the State's death certificate; and increased the number of autopsies that are conducted in cases deemed to be SIDS.

Colorado revised the State's death certificate and increased the number of autopsies that are conducted in cases deemed to be SIDS.

The California Model

The California State team began functioning before a law passed in 1992 made it official. The major activities of the State team are: coordinating and supporting activities of 45 local teams by sharing local reports, prevention programs and training; providing case and team consultation and training; supporting regional multi-county meetings; and assisting with multicounty and multistate programs and cases. Forty-five of the State's 58 counties have teams covering about 28.5 million people, which represents 95 percent of the State, or more than 11 percent of the Nation's population (Durfee, testimony, 1994).

The California State team established the Nation's first integrated State child death data system, using existing data contained in State indexes. The system matches case-level data on child homicide by county and by victim's age, using vital statistics from the Department of Health Statistics, child homicides reported in the California Department of Justice homicide file, and fatal child abuse and neglect cases from the State's Child Abuse Index.

The California State team established the nation's first integrated State child death data system, using existing data.

This crossreferencing helps ensure that cases are not missed by the system. Correction and matching of case-level data have improved information in each of these databases, improved interagency collaboration, and led to reforms in management of child abuse and neglect cases.

STRATEGIES FOR IMPROVEMENT

Toward National Leadership

Child Death Review Team members from many regions repeatedly testified before this Board that they need a common, national-level mechanism for sharing information, identifying trends, and giving voice to key issues concerning fatal child abuse and neglect that otherwise may not progress much beyond a team's own boundaries. There is a critical need to add to this in order to share protocols, legislative models and resources, as well as to address cases that cross State lines as families move or perpetrators flee.

There is a critical need to link State teams.

A national structure is needed to incorporate the knowledge of the teams, establish a mechanism for disseminating that knowledge, and facilitate development of a national perspective to prevent child abuse and neglect fatalities. This can be accomplished through the designation of individuals within the Department of Health and Human Services (DHHS) and the Department of Justice (DOJ) who could assume ongoing responsibility to support this process and the semiannual convening of experts from throughout the country to review and analyze relevant data, share information, track national trends, and develop recommendations. An annual report would be compiled and disseminated by the DHHS and DOJ staff.

We are not advocating a new bureaucracy, but a task-oriented structure and process. This would ensure that information and guidance are provided to States and localities seeking to initiate or improve their efforts to identify, review, and prevent child abuse and neglect fatalities.

We note that a national child fatality review team concept has strongly been endorsed by the Child Fatality Review Advisory Work Group of the Federal Interagency Task Force on Child Abuse and Neglect. Although our Board is not recommending the establishment of a formal team with defined membership, we believe the structure and process described above will accomplish the desired goals developed by the Task Force as a result of hearings held by the Health Resources and Services Administration's Maternal and Child Health Bureau (MCHB).

In addition, DHHS should designate an appropriate Federal entity to provide clearinghouse services to ensure that services and training materials are shared with all States.

Beyond the need for a national focus and an ongoing clearinghouse function, State and local Child Death Review Teams must be integrated into Federal and State health care planning. The health care establishment does not perceive child abuse and neglect fatalities as "their problem." DHHS can change both the perception, and the practice, if the Secretary directs that policymakers under her supervision work to integrate Child Death Review Teams into planning processes and policy development. The assistance of the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH) may be helpful.

We are already seeing heightened interest in Child Death Review Teams and maltreatment-related death by Federal agencies and national associations. In July of 1993 the Centers for Disease Control and Prevention, together with the Maternal and Child Health Bureau, sponsored a work group to help develop a model death-scene protocol.

The ABA Center on Children and the Law and ICAN are working under an the National Center on Child Abuse and Neglect (NCCAN) grant to provide models for training Child Death Review Teams nationally, update the rapidly changing map of review team locations, update the national directory, and create a newsletter. With the involvement of the Federal Government, all of these activities could be centrally coordinated, and the information they produce disseminated to their States and localities. Such an effort should lead to improvement in the expertise and effectiveness of Child Death Review Teams.

Confronting Confidentiality Obstacles

A RECENT CASE:

Douglas died in California at the age of 14 months of post-traumatic seizure disorder, but his autopsy showed the all-too-common evidence of past assaults: old subdural injuries and fluid collection. The local sheriff had taken Douglas away at 7 months of age with the head injuries that eventually led to his seizures, but a physician who had raised suspicions of abuse withdrew his suspicion and Douglas was released to his parents. Social Services followed the family with 5 months of voluntary services, and Douglas was sent for a medical workup to a children's hospital and a regional medical center. Both hospitals theorized, without having access to his medical or family history, that Douglas must have been injured by a traumatic birth. After Douglas died, a coroner finally reviewed Douglas' medical records and discovered that he had not experienced a traumatic birth. The medical examiner ruled his death a homicide.—Los Angeles Workshop, July, 1994.

Concerns over confidentiality were cited again and again by experts testifying before this Board as a real obstacle to saving children's lives. Child Death Review Teams encounter this problem daily. However, the ABA's published documents and testimony to this Board should allay fears among CPS workers, doctors, police, teachers, prosecutors, and others over criminal penalties or loss of Federal funding. The ABA has found that as long as Child Death Review Teams carefully manage their records, fear of criminal penalties or loss of funding within agencies who share their information is unfounded (Kaplan, personal communication, 1994).

"Too often, caretakers who abuse are given every opportunity to bury their deeds in the name of confidentiality, while we bury their children." — Randell Alexander, ABCAN Board member, Los Angeles Workshop, 1994

Federal regulations require that, in order to qualify for Federal funds under the Child Abuse and Prevention Act (CAPTA) and Titles IV-B and IV-E, States must enact laws providing that all records concerning reports of child abuse and neglect are confidential. Unauthorized disclosure is a criminal offense. However, these Federal regulations have specifically exempted multidisciplinary review teams from restrictions on sharing information within team settings (Regulation 45 C.F.R. 1340.11). Nevertheless, misconceptions about the law are widespread.

Many researchers and front-line workers believe these widely misinterpreted confidentiality regulations hinder the protection of children. Coroners and medical examiners, public health officials, and law enforcement agencies often encounter stubborn resistance from CPS officials who believe they must withhold their case information (Anderson et al, 1991).

Teams with established procedures for handling confidential information are proving they know how to handle sensitive information in a responsible way. However, this issue presents such a major obstacle that legislative clarification is needed at the state and federal levels. We urge the ABA, National District Attorney's Association, National Association of Medical Examiners, American Academy of Pediatrics, CDC, American Public Health Association, and law enforcement and child protection associations to push for implementation of model confidentiality legislation.

ONE STATE'S ANSWER:

Arizona law (Title 36, Chapter 35, Article 1) provides that members of a team, persons attending a team meeting, and persons presenting information to a team may not be questioned in any civil or criminal proceedings regarding information presented in or opinions formed as a result of a meeting. The law also notes: "Nothing in this subsection shall be construed to prevent a person from testifying to information obtained independently of the team or which is public information."

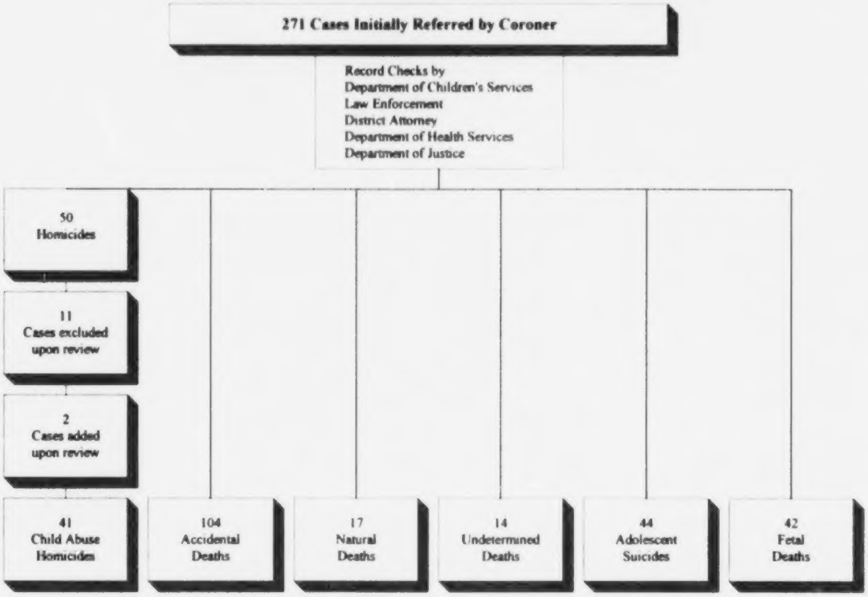
Better Team Design and Support

Differences in composition and function of Child Death Review Teams have not been systematically studied, in part because most teams are so new. However, there is a great need to determine which models work best and to show States ways to support those models. Suggestions from Missouri's experience include establishing an extensive Crime/Event Scene Checklist that ensures all pertinent aspects of an investigation are performed thoroughly and consistently; creating protocols to improve interviewing of victims, witnesses, and suspects; and improving photography and sketches of the death scene (Stangler & Kivlahan, 1993).

One well-established design is Los Angeles County's, the first team in the country. Every morning, the county coroner's office compiles a list of all child death cases that came to its attention in the previous 24 hours, and specific case information is sent to the ICAN, where it is routed to team members from the D.A's office, Department of Children and Family Services, Los Angeles Police Department, county Sheriff's Department, and county Department of Health Services. Members check their agencies' computers and files for any previous contacts with that child or family. The results of crosschecking are then returned to ICAN for analysis. The team decides which of the fatalities should be reviewed due to unique circumstances or questions and asks agency staff involved with a case to attend discussions and share their knowledge.

Deaths caused by abuse or neglect; all child suicides; and any accidental, natural, or undetermined child deaths that meet team protocols for review are compiled by the coroner in a year-end summary. In 1993, 271 reviewable deaths were reported by the coroner's office to the ICAN Child Death Review Team. Figure 1 summarizes how those 271 deaths were categorized and where discoveries led to changes in cause of death:

Flow Chart of Case Distribution for Analysis


271 Cases Initially Referred by Coroner
Record Checks by
Department of Children's Services
Law Enforcement
District Attorney
Department of Health Services
Department of Justice
50 Homicides
11 Cases excluded upon review
2 Cases added upon review
41 Child Abuse Homicides
104 Accidental Deaths
17 Natural Deaths
14 Undetermined Deaths
44 Adolescent Suicides
42 Fetal Deaths

Source: *ICAN*, 1994

Findings of all teams should be disseminated and used to improve efforts to prevent child abuse and neglect and resulting fatalities. Such reports also alert the community, State and Nation to the scope of fatalities. Each team should educate the public and recommend legislation to protect children. Team findings and efforts should also be integrated with all child and family service systems, including family support and preservation programs designed for families at highest risk.

While no official national standards exist for team design, this Board supports the following guidelines. Teams should:

- assure broad makeup with a range of viewpoints independent from any specific agency or entity;
- seek cultural diversity, including in their membership persons who competently reflect the various cultural concerns manifest in the issues of child death;
- include professionals from such fields as pediatrics, mental health, public health, nursing, medical examiners or coroners, domestic violence, substance abuse, CPS, law enforcement, education, vital statistics, developmental disabilities, and prosecution;
- be specifically authorized by legislation or government recognition;
- be given broad confidentiality waivers;
- monitor outcome data to assess team effectiveness in improving criminal justice response and other system improvements;
- make dissemination of findings a fundamental part of their mission;
- ensure that surviving family members receive appropriate grief counseling;
- work with fetal infant mortality review teams and others looking at causes of child fatalities;
- assure competency in, or have access to, resources for addressing issues of disability (e.g., hearing impaired);

- receive cases from public health or coroner's records;
- establish liaisons and collaborate with the military and Indian nations.

AN IDEA THAT WORKS:

Oregon approved a State law to provide noncompetitive grants to counties to support local Child Death Review Teams. Funds are raised through charges paid by persons convicted of felonies and misdemeanors. Most of the money comes from traffic tickets. The Deschutes County team, for example, receives $60,000 to $80,000 a year for staff and other needs. This could be implemented in other States.—Chris Gardner, Deputy District Attorney, Oregon Task Force on Sex Offenses Against Children, Oregon Public hearing, 1994.

Helping Surviving Victims

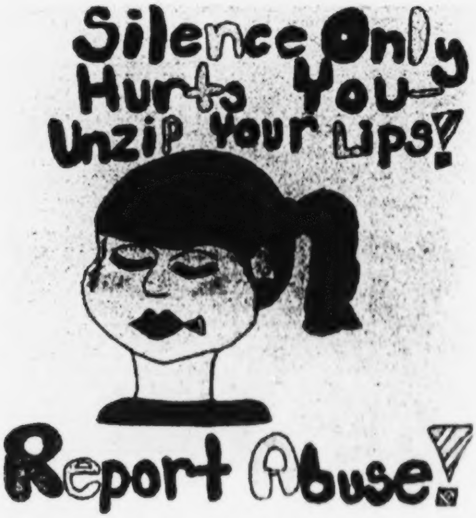
The findings of review teams make clear that the terrible human effects of child maltreatment fatalities go well beyond the dead child and the perpetrator. Surviving siblings may witness the abuse or suffer additional abuse, which can have a devastating impact upon them for decades. Siblings and other relatives need intervention and treatment, yet often receive few or no services. Crisis intervention and bereavement counseling are urgently needed (Durfee, 1994).

Michelle Kelley, a clinical psychologist in Denver, is among the few experts working with sibling survivors of fatal abuse and neglect. Her work has revealed a range of problems including post-traumatic stress disorder, sleep disorder, depression, anxiety, withdrawal and acting out. She has found that surviving children can be helped through involvement in the grieving process and by an ongoing support system (Kelley, verbal testimony, 1993).

Surviving children can be helped through involvement in the grieving process and by an ongoing support system.

In Los Angeles, ICAN's Child Death Review Team has convened a group of professionals, including therapists and line staff, to build a support system for surviving family members and others who have known someone who died as a result of child abuse or domestic violence. Their goal is to ensure that survivor needs are met through education, (e.g., how to plan a funeral), grief counseling, and personal and professional support.

Many families find comfort within their religious community. The clergy, therefore, represent a major resource to provide solace and grief counseling to surviving siblings and other family members.


Silence Only Hurts You- Unzip Your Lips!
Report Abuse!

Yanira
Lenicia B. Weemes School -- 5th Grade

CHAPTER THREE RECOMMENDATIONS

Our understanding of fatal child abuse and neglect is hampered by societal indifference combined with avoidance of the issue. In the 33 years since Dr. C. Henry Kempe first described the battered child syndrome, more children have died from child abuse and neglect than from urban gang wars, AIDS, or measles, yet the contrast in public attention and commitment of resources is vast. Diverting even a small fraction of our national attention and resources to an integrated and comprehensive approach to the defense of children's lives is a monumental task. Chapter Three's recommendations are designed to begin this challenging process through the use of Child Death Review Teams.

Recommendation 10: The Secretary of DHHS, the U. S. Attorney General, and the Secretary of Defense should work together to assure there is an ongoing national focus on fatal child abuse and neglect and to oversee an ongoing structure to support the national system of local, State, and Federal child abuse and neglect fatality review efforts.

This should include:

- Designation of federal agency contacts DHHS, DOJ, and the Department of Defense, who will have ongoing responsibility to support the process.
- The convening semiannually of a group of advisors to review the current status of child death review teams, team reports, data collection, intra-and interstate sharing of resources, as well as intra- and interstate management of cases that cross geographic boundaries. This will involve the reviewing and analyzing aggregate data, tracking of national trends, and developing recommendations on related policy and procedural issues.

To ensure needed expertise and diversity of views, equal or substantial representation should come from Federal agencies, State and local teams, national professional groups and programs, and individual experts. The DHHS and DOJ should provide support of this defined effort.

An annual report should be developed. This report would compile the information from the States, give a nationwide perspective on the nature and extent of child abuse and neglect deaths, and suggest preventive strategies. The report would be designed to assist professionals and educate the public and Congress.

Recommendation 11: A national-level effort should ensure that services and training materials on fatal child abuse and neglect are made available to all States by an appropriate Federal-level clearinghouse as designated by the DHHS and the DOJ.

Federal resources must be allocated to provide a far more meaningful level of expertise, technical assistance, and resources to professionals and agencies who need it. This effort is intended to support and augment the development of State and local Child Death Review Teams.

Because of the broad interdisciplinary nature of these issues, the Secretary of DHHS and the U.S. Attorney General should oversee this effort.

Recommendation 12: All States should have State-level Child Death Review Teams. Such teams should also be established within the military branches, Indian Nations and territories

- Every state should have a multidisciplinary, multiagency statewide Child Death Review Team whose membership includes criminal justice, health, social service, and other relevant agencies and individuals. Multidisciplinary, multiagency teams should also be established within the military branches, Indian Nations and territories. Teams should examine causes of all child death under age 18, with particular attention to unexplained and unexpected child deaths and others that may be caused by child abuse and neglect. Teams should publish an annual report that strives for uniformity of data collection with other States, summarizes case findings, and recommends system improvements.

- Federal support should ensure ongoing functioning of teams by offering incentives to create and maintain teams, and model team protocols and reports.

- State teams must be diverse, meeting the criteria previously described.

Recommendation 13: Child Death Review Teams should be established at the local or regional level within States.

Local multiagency, multidisciplinary teams are the core of the system, particularly for heavily populated States. They facilitate investigations and case management, suggesting system improvements and followup. In certain cases, regional teams should be established. These cases include rural counties that can share a single team and resources, border areas with other States or nations, and highly populated regions where counties want to share information and strategies. To facilitate communication between different locales as well as different agencies such as military and nonmilitary, liaisons should be identified.

Recommendation 14: Model legislation should be enacted to address confidentiality.

NCCAN should continue its work in this area. Legislation should provide clear legal immunity from legal sanctions for team members who share information in the course of the team's work, protect such information from judicial discovery, and specify protocols regarding public access to the teams' work.

Confidentiality barriers must also be removed between military and civilian authorities; within the military, between local, State, and Federal agencies; and Indian Nations.

States should enact legislation to clarify their ability to share information among law enforcement, CPS, mental health, and health agencies.

In addition, States should develop and maintain child abuse registries that provide updated and retrievable information on related fatalities. Investigation teams including law enforcement, CPS, and Child Death Review Teams, as well as other States, should have ready access to these registries.

Recommendation 15: States and communities should assure that the religious community is included in efforts to prevent child abuse and neglect fatalities as well as in the provision of grief counseling to surviving family members following the death of a child. The religious community should take a proactive role in becoming involved in these efforts.

As emphasized in the Board's 1993 report *Neighbors Helping Neighbors*, religious communities represent centers of service, places of acceptance, and a source of moral leadership in the comprehensive community-based child protection system. The religious community has a unique capacity to reach out to and provide support and counseling to families, including those with small children who are isolated from public service systems. As has been demonstrated in many States, the clergy could play a critical role in efforts to prevent serious and fatal child abuse and neglect. Members of the clergy also are a vital resource in the provision of personal support, spiritual guidance, and counseling to surviving siblings and other family members. The Board believes States and communities should actively seek the involvement of the religious community and encourage religious organizations to work together to increase their awareness, participation, and collaboration.

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"Your Children are not your children,
They are the sons and daughters of life's longing for itself,
...For their souls dwell in the house of tomorrow."
Khalil Gibran
The Prophet

CHAPTER FOUR

TOWARD A BETTER FUTURE: SERVICES AND INTERVENTIONS FOR CHILDREN AND FAMILIES AND FATALITY PREVENTION

PART ONE: SERVICES AND INTERVENTIONS

Child protective services (CPS), law enforcement and the juvenile courts have a statutory mandate to assume a major role to protect children from threats to their safety from parents and caretakers. However, as we as emphasized in Chapter Two, if the system is going to save children, the responsibility must increasingly be seen as a collaboration among social service, public health, education systems, law enforcement, and the courts. The elements of the final critical component are the neighbors, family, friends and local agencies that comprise a community. We must confront the fact that this larger system is not playing the role that it could.

"If I had my druthers, I'd chisel into the foundation stone or the archway of every child-welfare agency this simple statement: Our first job is keeping kids alive. And when we fail it's something for which the public doesn't forgive us."—Jose Alfaro, Director of Research, Children's Aid Society, New York Focus group, June 1994.

Federal efforts to protect children and prevent abuse and neglect have centered around four pieces of legislation. In 1974, two major laws were created: Title XX of the Social Security Act, which made funds available to States for a variety of social services, and the Child Abuse

Prevention and Treatment Act (CAPTA). CAPTA provided modest discretionary and state grants and created the National Center on Child Abuse and Neglect (NCCAN) to encourage prevention programs and offer technical assistance to States.

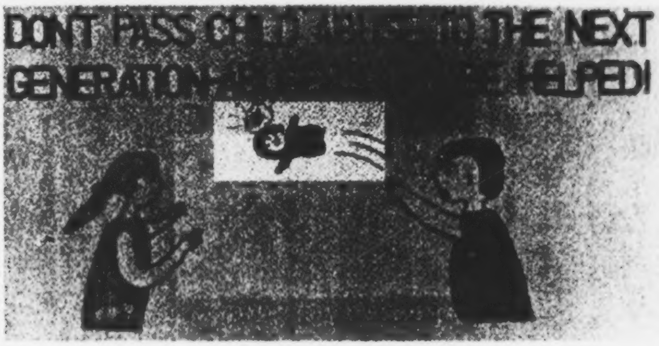
In 1980, the Adoption Assistance and Child Welfare Act (P.L. 96-272) was passed in hopes of preventing unnecessary placements and lengthy stays in foster care. The act required "reasonable efforts" to keep children with their parents, timely and safe reunification of families, and expeditious adoption for children unable to return home. But the State plans required by the legislation were so bureaucratic as to be unworkable; Judge Richard FitzGerald of Louisville, Kentucky, called them "a work of fantasy belonging in the fiction section of a bookstore" (Edwards, 1994, p. 28). Judges added to the problems, in that they often performed only cursory reviews of case plans submitted by CPS for specific families. States finally began operating Family Preservation Programs in the mid1980's, largely funded by reallocating money from foster care. This led to criticism that total funding to help troubled families and their children did not increase.

"Until all those geniuses out there cure poverty and the problems in the world, somebody's got to protect children, and you can't do that with good intentions. That's a perspective from the autopsy room. —Dr. Michael Baden, Director of Forensic Services, New York State Police, New York Focus group, 1994

The 5-year, $1 billion Family Preservation and Family Support Act (P.L. 105-66) has given States and counties a tremendous opportunity to shift from a crisis-response system to a system with the potential to reduce the core family problems that lead to abuse and neglect fatalities. In its most recent survey of 46 States, the National Committee for the Prevention of Child Abuse (NCPCA) found that most States intend to use about half of the money for family support services, and half for family preservation (McCurdy & Daro, 1994).

Family support programs differ substantially from family preservation programs in that they are designed to help overstressed and troubled families cope with and improve their circumstances before an incident of abuse or neglect occurs. The NCPCA notes: "This suggests that States are about to make the first tangible investment in child abuse prevention in recent memory" (McCurdy & Daro, 1994, p. 18).

It is the strong belief of this Board that this most recent legislation should be used to help remold the child welfare system into an integrated, prevention-oriented, community-based support system for families. In this chapter, we will present a plan for achieving these and other crucial goals.



Jamie
Washington School — 6th Grade

CURRENT ISSUES

Inadequate Services and DecisionMaking

Testimony before this Board in 1993 and 1994 showed that child protection workers struggle on a daily basis to make responsible decisions about providing services to troubled families, but often lack the time, tools and money to provide families and children with the help they so obviously need.

Child protection workers struggle on a daily basis to make responsible decisions, but often lack the time, tools, and money to provide the help they so obviously need.

Perhaps the most alarming trend is the frequency with which no services for children and families are offered at all. According to the NCPCA survey, 22 States in 1993 indicated that almost one in three families in which abuse or neglect was substantiated *received no counseling, intervention, or other help*. That translates to some 300,000 cases of substantiated abuse or neglect that received no basic social services to counteract the effects of abuse or neglect, or to prevent future problems (McCurdy & Daro, 1994). Moreover, current programs rely heavily on counseling or parenting classes, when overburdened parents often need a few hours respite from the child or help in coping with spousal abuse (Ewigman, verbal testimony, 1994; Nazario, verbal testimony, 1994).

"Prior contact with CPS does not imply that the family received needed help. We have reason to believe the vast bulk of CPS reports end with the investigation, whether abuse is found or not."—Murray Levine, ABCAN board member, New York Focus group, 1994

In many regions and agencies, a debate is underway regarding which decision-making guidelines should be applied to the thousands of high-risk cases that come before CPS agencies each year. A study by Cornell University found that the desire of caseworkers to reward or punish certain parents, the internal values of the particular system, and efforts by caseworkers to anticipate how a judge might rule all influence whether a family receives services, court intervention, or nothing at all (Alfaro, verbal testimony, 1994).

Efforts are underway to provide workers with better decision making tools. For example, researchers at the University of Chicago are attempting to describe, for possible wider use, a decision-making model used by experienced, highly trained CPS social workers (Chapin Hall Center for Children, 1989). Protocols for assessing family risks to a child's safety have been developed in the past decade. Unfortunately, the purpose of risk assessment has become seriously diluted and confused. Risk assessment tools were meant to draw CPS staff attention to circumstances that research indicates are correlated with abuse and neglect. The intent of risk assessment was to identify predictive factors so that appropriate prevention strategies and interventions could be developed and implemented.

However, many elected officials, policymakers, and the public have come to believe that assessment tools can be used to *accurately predict* which parents are going to kill their children. This is not supported by design or research and is far beyond the intended purpose of risk assessment instruments. It is difficult to devise risk factors to predict abuse or neglect with accuracy. It is all the more difficult to predict child deaths.

Confusion Over and Misapplication of Family Preservation Services

Over a decade ago, in the State of Washington, Behavioral Sciences Institute, Inc., developed the Homebuilders service delivery model. This model was designed to help families through crises by providing intensive, home-based services for 6 weeks. Because many families had ongoing problems, the program linked families to longer-term social services after the crisis ended. The program helped families through a variety of difficulties, including reports of child abuse and neglect that might otherwise have resulted in a foster care placement.

Because of the potential of this program model to help children and families and to avoid foster care, its strategy became central to the discussion of the 1980 Adoption Assistance and Child Welfare Act and to its emphasis on making "reasonable efforts" to avoid foster care. Many jurisdictions have since adopted or adapted the Homebuilders model.

However, as highlighted in recent media reports and in testimony before this Board, the expansion of family preservation efforts has given rise to a number of controversies that have a direct bearing on child fatalities.

"It is difficult to balance family preservation policy with the understanding that some children require immediate intervention and removal."—Jane Beveridge, Child Protection Program Administration, Colorado Focus group, 1993

First, the term "family preservation" has different meanings in various jurisdictions. In some areas, family preservation refers to a philosophy of child protection, complete with its own set of guiding principles. In others, it has a more pragmatic meaning: a specific set of intensive services available 24 hours a day to families in crisis. In still others, "family preservation" is used as a general rubric to indicate avoidance of foster care. As a result, tremendous confusion has arisen. Researchers, policymakers, and the public are equating incompatible definitions and programs, leading to further misunderstanding.

Second, some supporters of family preservation programs inappropriately promote them as a "magic bullet" able to meet all needs of any family. As a result of such thinking, jurisdictions too often use programs indiscriminately for any family reported for child abuse or neglect.

Finally, family preservation programs have been promoted primarily as a way to save money on foster care. Unfortunately, saving public funds is too often made the only goal or the primary goal, while far more important goals—such as helping families negotiate a crisis or using foster care to protect children—have taken a back seat.

In view of today's debates over "reasonable efforts," this Board assumes that Congress intended jurisdictions to make efforts to avoid placing children unnecessarily in foster care *only if the safety of the child could be reasonably assured.* It is clear that future State and Federal legislation focused on families and children must explicitly state *all* desired goals, including child safety, to avoid putting children at risk for injury or death.

Congress did not specify that the "reasonable effort" take precedence over assuring a child's safety.

These are pressing problems that must be addressed if family preservation is to succeed and if children's lives are to be saved. We will recommend a number of ways to clarify and improve family preservation programs and to change the sometimes haphazard manner in which families are selected for this important service.

Inappropriate Placements

Whenever a child's safety is in serious jeopardy, that child must be removed from the custody of the parents—temporarily if it appears that safe reunification with the parents is feasible in the foreseeable future, and permanently, if there is no reasonable likelihood of safe reunification.

"To answer your question about when do you step in— to me it is not unconstitutional to step in if I send a child to school and the child has my handprint on their face. You took away that child's rights. Now we take away your rights." — A Woman of the Family Violence Program, Bedford Hills Correctional Facility, 1994.

Today, the number of child abuse and neglect-related fatalities in foster homes and in children's institutions appears to be relatively low (McCurdy & Daro, 1994). However, it must be recognized that removing a child from the parental home does not guarantee a child's freedom from abuse, neglect, or even death. Because foster homes, group homes, and residential treatment centers act on behalf of the larger society to care for children taken from their parents, governance bodies for such institutions, as well as government itself, must take every step to assure that children are safe in these facilities.

...removing a child from a parent does not guarantee a child's freedom from abuse...

In recent years, the number of children living with relatives as an alternative to foster care has increased dramatically. This Board generally supports the trend toward having extended families provide this traditional support. For many children, living with relatives is positive as it continues family contact while protecting the child and it allows the child to stay in a familiar area and school.

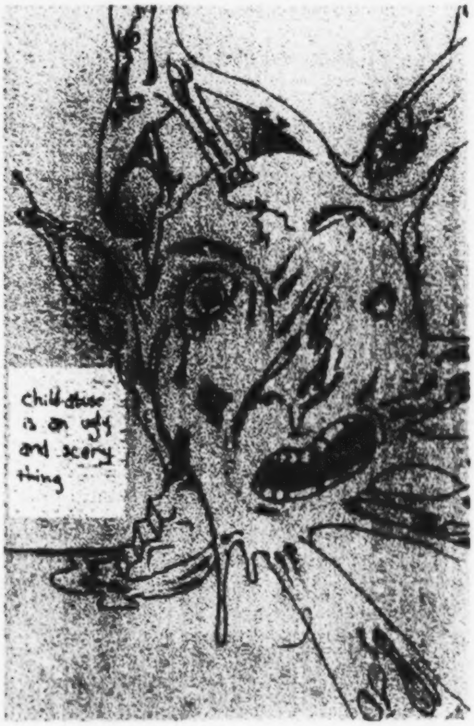
The kinship care issue is complex, and we cannot attempt an indepth discussion in this report. However, we wish to emphasize that the importance of staying with family does not supersede the importance of providing children safe, nurturing, and healthy environments. When kinship care is used, appropriate services must be provided. For example, financial support for relatives is as critical for meeting the child's needs as is the financial help given to foster parents. Similarly, the social services and therapeutic support provided to children in foster care are often equally needed by relatives providing care to children who have been abused or neglected. However, if relatives or kin are not capable of providing care, support, and adequate supervision of a child, despite the system's best efforts, then a safe foster care setting, with well-trained caretakers, is more appropriate.

"My oldest son was placed with my sister, but my brother-in-law was abusive. My son would come (visit me in prison) and he'd cry and say, 'Mommy, nobody believes me.' So I called the social worker. She goes there, everything is fine. What about the bruises? Oh, he hurt himself while playing outside. He fell. He got into a fight. But it's not true."—A Woman of the Family Violence Program, Bedford Hills Correctional Facility, 1994

A highly publicized example of improper extended family placement involved a Chicago youth, "Yummy" Sandifer. Yummy was first seen by the authorities when he was a 22-month-old with bruises and scratches. A year later Yummy and his six brothers and sisters were removed from their mother's care. The children's mother was a crack addict who had been arrested 41 times. At the time of the children's removal, an older brother was blind because of neglect; a sister had second degree burns because of a "fall on a radiator"; and Yummy had welts on his legs from an electrical cord and burns and bruises on his shoulders and buttocks.

The children were placed with the maternal grandmother even though her psychiatric report described her as having a "severe borderline personality disorder." Either because of court placement or abandonment, the grandmother was responsible for the care, at one time or another, of 30 grandchildren in a 3-bedroom house.

At age 11 Yummy was wanted for the murder of a 15-year-old girl. The victim was shot when Yummy fired a 9-mm semiautomatic weapon into a crowd of kids playing football. A few days later Yummy was murdered. At the time of his death, Yummy had 23 felony arrests (Gibbs, 1994; *Los Angeles Times*, 1994, p. 1). We cannot know whether Yummy's life would have turned out differently if he had been placed in a less problematic environment. Nevertheless, it is reasonable to deduce that in this case, keeping Yummy within his biological family was not the appropriate course.



Jeremy —Special Education
Division
Fair Avenue School

STRATEGIES FOR IMPROVEMENT

Intensive Family Preservation Services

This Board believes that when family preservation programs are designed well, perceived dichotomies between child safety and preservation will be seen as artificial. Family preservation, as a philosophy and as a program model, should seek to keep families together only when the safety of all family members can be reasonably assured. Some critics, including some domestic violence program leaders, perceive some family preservation programs as attempts to keep families together even while adult violence continues in the household. However, no legitimate program will promote family preservation "at all costs," and no agency should have such a practice.

On the contrary, it is critical that CPS and domestic violence programs explicitly state that they will first conduct a review of risk to all family members and will decide to pursue preservation efforts only if it presents a reasonably safe strategy for the child and others. Family preservation is not a magic bullet, and it need not be tried for each family. It should rather be included among an array of options when considering alternatives to foster care that are in the "best interest" of the child.

There is insufficient research indicating whether existing family preservation programs achieve the goal of protecting children while saving families. It is also unknown which families receive the most benefit, or which problems in a family are best addressed. Moreover, there are no meaningful data that compare child deaths or serious injury within family preservation programs to data on child deaths or serious injury among similar families who have other interventions, such as foster care.

Family preservation is not a magic bullet.

Despite the lack of conclusive outcome data, this Board recognizes family preservation as both an appropriate philosophical goal and as a legitimate model of service delivery. The limited amount of research should not prohibit its use any more than the lack of research prohibits using other interventions.

While each community must define the array of services it will provide, we believes that family preservation services should be available in every jurisdiction. We suggest below several critical elements to a strong family preservation program model, which we describe more fully in Recommendation 20.

"The preservation of families is an important goal, but not more important than the safety of children. All of us should be seeking to keep families together—as long as we can provide for the safety of all family members."—Michael Weber, ABCAN Board member, Director of the Program for the Community Protection of Children, Washington DC Board meeting, 1994

- Child safety is always a priority in any service decision.
- Ongoing assessment of the family service plan and of potential risk is critical. This would include a culturally competent assessment of both family strengths and problems, which is critical to implementing a viable service plan that respects family heritage or tradition. Workers must assure that abuse is not allowed under the guise that it is culturally appropriate.

Services should be:

- Comprehensive.
- Provided primarily in the family's home or apartment, including face-to-face contact with all of the children and family members.
- Intensive, particularly during the period of crisis.
- Provided by staff with small caseloads who are available 24-hours per day, 7 days a week, from multiple agencies in the community with specialized staff available as needed.
- Designed with time-limited goals, with ongoing evaluation as to goal achievement.
- Closely related to other long-term services to meet a family's needs after the crisis is over.

- Guided by values emphasizing active family participation as well as protection of the child.

We emphasize that family preservation, correctly designed, is a crisis intervention model that can help a family through difficult situations that might otherwise lead to the placement, abuse, or neglect of a child. However, a 6-week program does not constitute a complete program of family therapy. Six weeks cannot reverse a long pattern of unacceptable childrearing or a lifetime's acquiring of inappropriate social skills.

To make long-term changes, family preservation services must include the flexibility to ensure that families receive help over a longer time period and are supplemented by a complement of needed services, such as mental health, substance abuse, domestic violence counseling, respite care, shelters for battered women, health care, and homemaker assistance. This is one of the necessary interactions between family preservation services and the broader array of family and children's programs.

Family preservation services must include the flexibility to assure families receive help over a longer time period.

ONE PROMISING EFFORT:
In Los Angeles County, child safety is the top priority of the Family Preservation program. All CPS workers and community network service providers must formally agree to this priority. Under a pilot program, decisions on whether a child is taken into custody or remains home and is enrolled in a preservation program are made by the Child Abuse Response Unit, comprised of a sheriff's deputy specializing in child abuse and a social worker. The team responds to abuse reports and jointly assesses the family. One important tool is a "red flag" list of five parental factors and three child factors that put a child at high risk for serious injury or death. If either team member feels the child is in danger, *the family is not chosen* for the program. If the family is selected, a network of community agencies develops a customized plan of services and ongoing evaluation. The program was developed in the wake of public criticism that children were not protected while participating in family preservation programs.—Bruce Rubenstein, Deputy Director, Los Angeles County Department of Children's and Family Services, New York Focus group, 1994.

Expedited Decisions on Permanence

For some children, attempts to seek a safe reunification with their parents will fail. For others, particularly in egregious cases of abuse, it will be immediately clear that the child cannot be returned home safely. In both cases, an alternative family must quickly be sought. However, there are no national standards or policies used to guide decisions on when to seek termination of parental rights (TPR). Michigan, Washington, Iowa, and Oregon are among the few States with written guidance on thresholds for situations requiring removal.

"We often neglect to consider the high risk to children who are born unplanned and unwanted. One of the most effective ways to prevent serious and lethal child abuse and neglect is family planning."—Dr. Harry Wilson, Providence Memorial Hospital, El Paso, Texas. Denver Public hearing, 1993

When caseworkers reasonably believe enough changes will be made in and by the family to permit a safe reunification, services designed to promote those changes must be started as soon as the child enters foster care. Otherwise, their efficacy will not be tested, and the child may linger in foster care.

Communities increasingly realize that some children must be removed from their parents' custody through legal TPR and quickly placed in stable, nurturing, permanent homes. But all too often, this does not happen. Confusion over what constitutes "reasonable efforts," as described earlier, has actually resulted in longer foster care stays for children in some areas as agencies make multiple attempts over many years to reunite problematic families. New York City released a study in December of 1994 that found that foster children in New York now languish in foster care for an average of nearly 4 years, instead of the 2-year average in 1988 (*New York Times*, 1994).

A troubling example is that of the siblings of Adam Mann, two young boys who struggled through many foster care placements after both parents were convicted in the killing of the boys' little brother. Officials agree that TPR should have been completed, but it was not, and the children might be returned to their mother when she is released from prison. The controversy has set off a debate, with many arguing that the boys were victimized twice—first by their own parents, then by the system (Langer, 1991).

TPR takes years in many States and counties, even in obvious cases of severe abuse or neglect. However, as we discussed in the 1993 U.S. Advisory Board on Child Abuse and Neglect (ABCAN) Report *Neighbors Helping Neighbors*, some areas are addressing this problem (ABCAN, 1993).

It is critical that once expedited termination has occurred, preference for placement must be given to extended family members and kin, *if* those adults are able to safely care for and nurture the child. If the child is old enough, his or her wishes should be considered. There must be far more intensive efforts to recruit quality permanent homes and to develop family-like residences. For adoptive and long-term foster care recruitment to work, and for good adoptive and foster care families to be retained, policies must support the care and services needed for the child.

ONE GROUP'S VISION:

Court Appointed Special Advocates (CASA's) are often used to keep children from languishing in foster care. CASA's are trained volunteers appointed by judges to represent the best interest of children in the courts. CASA programs operate in all 50 States, the District of Columbia and the Virgin Islands. This program is designed to help mostly older children. By late 1994, there were 36,000 trained CASA's advocating for 110,000 children. CASA children spend about 15 months in foster care, compared to the average 27 months. In Texas last year, CASA saved over $40 million in foster care costs, and helped prevent many children from drifting through the system without receiving a final decision on permanence.—Jane Quentan, Executive Director, Texas CASA, Dallas Public hearing, 1994.

PART TWO: FATALITY PREVENTION

We, as a society, want swift action and clear-cut policies. We abhor what appears to be the failure of the system and the passing of the buck. However, after 2 years of testimony from experts in a wide range of fields, this Board is convinced that the public debate over who "made a mistake" that led to a child's death usually focuses on the wrong issues. The best chance we have for reducing these deaths is by focusing on the right issues.

Who Is At Fault?

Mistakes are sometimes made in clear-cut cases of danger to a child, and these tragic human errors deserve media or public attention. But when the Chicago Tribune asks, in its 1994 series on child homicides, "Who is at fault?" for failing to rescue children from households that are clearly in turmoil, the unfortunate answer must be: usually, no one person or agency is at fault. The difficult truth is that, except in obvious cases of imminent danger, no individual has the understanding or scientific tools needed to foresee serious abuse or neglect that causes the death of a child.

Chances are high that most of the families in which a child will die will escape notice until the death occurs.

One challenge faced by those who deal with high-risk families who might seriously harm or kill their children is the difficulty of predicting which family will actually become a statistic. Because child abuse and neglect deaths are a "low base-rate" phenomenon, with about 2,000 deaths as compared to about 1.9 million reports of abuse and neglect, chances are high that a professional cannot predict which particular family will become so abusive or neglectful that their child dies (McClain et al, 1993;

NCCAN, 1994). Chances are also high that most of the families in which a child will die will escape notice until the death occurs.

However, it is possible to identify and address the families at highest risk for potentially fatal abuse and neglect because the population of seriously abused and neglected children who each year are severely injured (141,700) or left with permanent damage (18,000) is not a "low base-rate" phenomenon (NCCAN, 1991; Baladerian, 1991). We need to pay more attention to intervening with families who are at high risk for potential injury.

The effort is analogous to the war against polio, in which hundreds of thousands of children at risk were inoculated because it was impossible to determine which among them would actually contract polio. This was not perceived as a wasted effort but as a rational prevention strategy. Today, tens of thousands of infants and small children are living in situations that could pose a risk to their safety. For example, in 1992, 14.5 million families with children were living in poverty (NCCAN, 1994; Bureau of the Census, 1994). In 1993, between 500,000 and 650,000 parents and children were living in the streets either temporarily or permanently (personal communication, Debbie Chang, National Alliance to End Homelessness); 3.3 to 10 million households with children contained a violent male with a history of domestic abuse (Schecter & Edleson, 1994), and 11 million parents were abusing drugs and alcohol (personal communication, Narconon, U.S. Drug Education Division). Poverty, history of violence, and substance abuse are all warning signs of child fatality or injury from abuse or neglect. In families where these risks overlap, which they often do, the threat is believed by experts to be greatly increased.

"We keep saying the cause is poverty—and I think sometimes we libel poor people—the truth is, most poor people don't abuse and neglect their kids."—Jose Alfaro, Director of Research, Children's Aid Society, New York Focus group, 1994

Because we lack the capacity to identify which children might die at the hands of their parents or caretakers, this Board is urging Congress, the states and policymakers to develop prevention strategies that provide nonstigmatizing, readily available, culturally acceptable resources to assist all parents in their task of caring for their children. At the same time, we must redouble our efforts to reach families at high risk for severe or fatal abuse and neglect. By creating a comprehensive safety network for all children, including those clearly at risk, we can hope to improve the lives of many families, and thus protect those who need help the most.

Addressing the Perpetrators

As we have emphasized, researchers have not identified a consistent set or cluster of personality traits that can accurately predict which parents will become extremely abusive or neglectful enough to cause severe injury or death. However, the experiences of dozens of Child Death Review Teams and thousands of front-line workers continue to bear out the fact that many such parents stand out because of behavioral, emotional, and cognitive difficulties; histories of other violence; involvement in substance abuse; and highly negative views of themselves and their children.

> *"We don't create safe places for people. We create punitive places. We create judicial places. But we don't create safe environments for a mother to come and say, look, I don't like how I treat my children." —Sharon Smolick, Director, Family Violence Program, Bedford Hills Correctional Facility, 1994*

Abusive parents, when compared to nonabusers, show greater physiological reactivity, irritation, and annoyance in response to both their children's *positive and negative* statments and behaviors (Casanova et al 1992). They often perceive their own children as more aggressive, disobedient, stupid and annoying than other children, even though non-family observers see none of these problems in the children (Mash et al 1983; Reid et al 1987). Studies have identified parental characteristics associated with child abuse and neglect: low self-esteem, poor impulse control, depression, anxiety, and antisocial behavior including aggression and substance abuse (Pianta et al, 1989).

Given these many deep-seated problems among seriously abusive or neglectful parents, it is not surprising that little definitive research exists that "demonstrates reductions in re-abuse among parents who receive parent training" (NRC, 1993). Because the challenge is so great, and few efforts have made a significant difference in altering abusive and neglectful parental behavior, this Board will offer recommendations designed to improve primary child abuse and neglect prevention efforts and more consciously focus on the high-risk parent population in which most abuse and neglect deaths and serious injuries occur.

> *"Policymakers need to see the beaten woman when they see the beaten child, and recognize that battered women have few real choices and simply cannot leave."—Alana Bowman, Office of City Attorney, Domestic Violence Unit, Los Angeles Focus group, 1994*

Understanding Domestic Violence

The role of domestic violence in fatal child abuse is rarely discussed in studies. Nevertheless, some experts argue that domestic violence is the *single major precursor* to child abuse and neglect fatalities in the United States (Stark, verbal testimony, 1994).

Child protection professionals rarely identify, report, or intervene to stop or prevent domestic violence.

Child protection professionals rarely identify, report, or intervene to stop or prevent domestic violence. According to Stark, almost half of the mothers of abused children are being battered. Children not only become covictims, but, Stark argues, they mimic abusive behavior (Stark, verbal testimony, 1994). Many women may be discouraged from reporting spousal abuse or related risks to their children for fear they could lose custody of the children.

Because fathers and other males are difficult to reach through traditional avenues such as health care and social programs, and because policymakers have for so long focused on mothers, many prevention programs are directed to single mothers who, in fact, do not play the dominant role in child abuse and neglect fatalities, and may themselves be victimized by the males in their lives. For example, Missouri officials were recently stymied by this problem as they designed a new clinical trial. The trial involves intensive intervention for infants and toddlers whose mothers receive public assistance from the Women, Infants and Children Program (WIC) and who use physical discipline, score high on an anger scale, and are believed to be at high risk for abuse. Ultimately, Missouri officials decided that it was hard enough to persuade mothers to attend training or to allow home visiting, and almost impossible to persuade men, so men were not included.

"It's important to have help in the neighborhood where the kids can go. But we need to educate the neighborhood, because I wouldn't go to my neighbor's house either when I was being abused as a child. They were beating the shit out of their kids. I wouldn't go there."—A Woman of the Family Violence Program, Bedford Hills Correctional Facility, 1994

The Challenge of Helping Hard-Hit Communities

Some neighborhoods suffer a highly disproportionate share of child abuse and neglect fatalities; however, the cause remains unknown (NRC, 1993). It is often assumed that certain neighborhoods promote violence and household isolation, which can be factors in abuse by parents. Researchers point out that it is equally possible that troubled neighborhoods can develop when violent, disruptive families group together as more stable families leave a declining area. However, fatalities have been shown in a few studies to be as common in very isolated rural areas as in very poor urban districts, despite a long-time assumption that this is an inner-city problem (Jason et al, 1982; Stangler & Kivlahan, 1993).

Household isolation that keeps neighbors, friends and relatives away is believed to play an extremely important role in serious and fatal abuse and neglect of infants and small children. The parent or caretaker receives no parenting support and continues to act inappropriately in complete privacy since the child is too young for school, where he or she has a chance of being noticed by a teacher or other adult.

Some neighborhoods suffer a highly disproportionate share of child abuse and neglect fatalities.

The National Research Council (NRC) noted in 1993 that much more must be learned about using networks of friends and relatives as prevention systems. Household isolation may be a result of neighbors and relatives rejecting parents with deviant behavior; thus, these families may have no social network that will willingly help. On the other hand, abusive parents may select friends or maintain ties with relatives who condone their maladaptive parenting styles, increasing the likelihood of continued abuse or neglect of the children (NRC, 1993).

The Problem of Overselling Prevention Efforts That May Not Work

Because we do not yet fully understand how to prevent many child abuse and neglect fatalities, it is important that policymakers not oversell promising new programs that may fail to live up to hopes or backfire due to human error or unanticipated problems. This could generate further negative public reaction and perhaps even put children's lives in danger by creating a false sense of security.

An example in Illinois demonstrates how human error can compromise even promising new programs. Recently, the State experienced the starvation death of a child who had just been visited by three child protection workers in a program that gave the family intensive in-home attention and services. Each of the workers merely believed the child to be underdeveloped. Yet at death, the child was 5 years old and weighed only 25 pounds (McCurdy, verbal testimony, 1994).

Many prevention efforts are based upon the idea that enough education will stop inappropriate parental behaviors. But there are numerous examples of parental education missing the mark, indicating that many parents either need to learn far more effective coping skills or need more vigilant monitoring. For example, a man was recently convicted in Iowa for inflicting severe brain damage on a baby he had violently shaken. The mother was also convicted for failing to stop his many attacks. The man later admitted seeing Des Moines-area public service TV spots warning about Shaken Baby Syndrome and stated "I knew that I would never do anything like that to a baby" (Randy Alexander, verbal testimony, 1994 Board meeting).

A variety of improved prevention efforts can be developed in response to better information. For example, to prevent an infant from falling from an apartment window, building codes may be modified to require window guards with safety latches. While such so-called "engineering" solutions may seem easy to implement, it is quite another matter to prevent a father from severely beating a toddler for failing toilet training, or to convince a drug-addicted mother to stop leaving her baby at home alone for hours on end. Success at preventing such behavior will remain elusive until we know more about the causes.

A RECENT CASE:

The investigation of the death of a young child revealed that the family was actively involved in a home visiting program, but the home visitor had not wanted to involve CPS in the family's many problems because CPS was viewed as a negative entity. CPS, in turn, did not want to involve police because it saw law enforcement as a negative entity. In the end, the child quite possibly died in part because agencies did not know, trust, or like each other and were convinced that they each offered the best answer.—Dr. Michael Durfee, Los Angeles Hearing, 1992.

STRATEGIES FOR IMPROVEMENT: CASTING A WIDER NET

This Board believes a universal approach that reaches all families is the best fatality prevention strategy at this time. This effort must begin with services such as universal home visiting by trained professionals or para-professionals, hospital-linked outreach to parents of infants and toddlers, community-based programs designed for specific neighborhoods, effective public education campaigns and innovative ways to reach males.

Research suggests that the same basic kinds of high-risk family situations are producing both fatally and seriously injured children.

Research suggests that the same basic kinds of high-risk family situations are producing both fatally and seriously injured children (Hegar et al, 1994; Goldstein et al, 1993). If true, prevention efforts directed at the larger group of families with the potential to seriously injure their children will encompass the smaller group of families at risk for fatalities. With the right approach, we also may be able to prevent so-called "serial" fatal abuse and neglect by parents who have already lost one child but remain undetected by the system because the death was diagnosed as accidental or natural (Alexander et al, 1990; Olds & Kitzman, 1993).

Broadly Expanded Voluntary Home Visiting

Universal home visiting for new parents who voluntarily accept such services, a previous recommendation of this Board, is a promising model for helping children and families in need. Hawaii, Iowa, and New York have already approved legislation that encourages comprehensive home visiting efforts. We strongly reiterate the pressing need for voluntary home visiting.

There is one dramatic, unifying factor upon which home visiting and early interventions can be built: studies show that 75 percent or more of deaths from abuse and neglect strike children under 5 years of age (McClain et al, 1993, Levine et al, 1994; Levine et al, 1995). This preponderance of death among the very young underscores the fact that current interventions often do not reach the smallest children, who are in the deepest trouble and yet are largely invisible to CPS agencies.

"My best guess would be that having an extra set of eyes in the home would allow people to identify problems earlier and help families get more support, and that's why we support the model. But it hasn't been proven that that's the case. Not yet."—Karen McCurdy, Principal Analyst, NCPCA, New York Focus group, 1994

However, home visiting is not a panacea, and its value in reducing abuse and neglect fatalities has not been conclusively proven. Home visitors may be public health nurses, paraprofessionals, or trained indigenous workers. While indigenous workers may provide rapport with a family, early research has shown problems when these volunteers sympathize with the client or project their personal situations onto a client (Daro, 1993). Another problem is the labor and cost-intensive nature of home visiting programs, which is critical to the design. For example, Hawaii's Healthy Start program costs $7 million dollars a year and serves 52 percent of families with newborns (Breakey & Pratt, 1993). these costs, however, are far below the expense of out of home care that could result from a lack of these preventive services.

Home visiting must be integrated within a comprehensive service system of parent education respite care, housing, and prenatal care.

Nevertheless, efforts such as Hawaii's Healthy Start, NCPCA's Healthy Families America, and the Minneapolis Visiting Nurse Program seem promising because they are based on a preventive, public health or paraprofessional model, not on an arbitrary intervention model. To date, however, no controlled study has been done of Hawaii Healthy Start to compare its families' abuse, neglect or death rates with other interventions for comparable families (McCurdy, verbal testimony, 1994). The NCPCA believes such studies are necessary, and we wholeheartedly agree. We also recognize that home visiting must be integrated within a comprehensive service system of parent education, respite care, housing, and prenatal care.

Reaching New Parents

"When a child is born, we immediately do a test which is called an Apgar, used to predict the mental and physical development of the newborn. We should also do an Apgar on the parents."—Frederick A. Ward, Randolph, Mo., County Coroner, St. Louis hearing, 1994

In describing government programs that work, Vice President Gore has used the analogy of "on-time delivery" in manufacturing, which means that all materials necessary to create a product are available at the precise moment needed. In the case of families, this Board believes pregnancy and the birth of a child are special opportunities for growth, when "on-time delivery" of services must be made available, before families develop habits or difficulties that could threaten the safety of their new child. If given help early, we believe most families in need, and their children, will benefit.

A well-designed public education campaign can go a long way.

In addition, this Board believes some parents do not comprehend how an infant or small child can be killed during a single assault or an act of extreme carelessness. A well-designed public education campaign can go a long way toward dissuading parents from using violence or leaving infants and small children alone in what can quickly become perilous situations.

One Community's Effort:

The Parenting Education Program (PEP) is a low-cost primary prevention program that identifies high-risk parents while at the hospital. PEP offers both adult and teen parent training, help for substance-abusing parents, and training of professionals and volunteers in parenting risks to children. In 1994, PEP served 500 adult mothers, 87 teen parents, and 19 substance abusing parents.—Laurel Whitaker, SUNY Health Sciences Center.)

Creating a Caring Community

The Board presents this report on fatalities in response to public concern, a congressional mandate, and the Board's longtime belief that addressing child fatalities carries a moral and ethical imperative that provides an important window into the difficult lives of millions of abused and neglected children.

However, we emphasize that each community must not raise concerns only when a child dies. Rather, the tragic death of a child should serve as a reminder that this Nation needs to create a comprehensive CPS system that helps families *before serious abuse or death occurs*. Child deaths are a sign of the failure of total support systems, including the community of neighbors, friends, and family who must be alert to children living in households at high risk of abuse or neglect.

Each community must not raise concerns only when a child dies.

A RECENT CASE:

The little girl had been bitten on the cheek, and a medical examiner's investigation later showed, that she had received severe internal injuries that killed her. Detectives determined that she had been used for karate-kicking practice by the boyfriend of the mother, in front of the rest of the children. She was beaten intermittently for more than a week. Many neighbors in the well-to-do Nassau County, New York, neighborhood saw her badly marked face. But neighbors did not think it was their business, and the family was not reported. Only when the child was killed did the beatings come to attention of authorities. Caring communities must take action to save children from abuse if this tragedy is to be prevented.—Dr. Michael Baden, Director of Forensic Services, New York State Police, New York Focus group, 1994.

A community system should be built upon the philosophy that families need help, support, and encouragement in raising children. Natural supports such as extended families, relatives, friends and neighbors have traditionally played this role, but such support is often lacking in the very families most in need of it. Low-income families often move from place to place, neighbors sometimes believe it is not their concern, and in some devastated urban areas, residents are so accustomed to violence that even the abuse of an innocent child can get lost in the turmoil.

"If you see your next-door neighbor, and all of a sudden she's got the dark glasses on and she's walking around with her head down, you know she's covering up black eyes. When they can't talk themselves, we must talk for them. That may be the saving factor." — A Woman from the Family Violence Program, Bedford Hills Correctional Facility, 1994.

Yet even in these highly stressed, poor, urban communities where child abuse and fatality rates are high, local agencies and individuals can help families move in a more positive direction. The same argument can be made for rural communities. We believe most parents are eager to be their child's nurturer, first teacher, and coach as they grow toward adulthood. With community support, most parents can be.

As we made clear in Chapter Two, the fact that a number of families with children who die from abuse or neglect were known to at least one public agency is not necessarily a condemnation, but an opportunity to learn and improve. We hope this report will inspire the level of community commitment necessary to create a comprehensive neighborhood-based system, which previous ABCAN reports have envisioned.

In our 1993 report *Neighbors Helping Neighbors*, we described the theoretical basis for a community-based system. We would like to be able to say that this model now exists in many cities, but no areas have yet adopted a complete system. This Board hopes this model will be broadly adopted soon.

Briefly, the values of such a system must address the three key goals of: child safety, child well-being, family preservation. The community system must include a network of primary services and family social services which, along with income supports, assist parents in providing for their child's safety and well-being. However, unless both parents in a two-parent family are included this is often difficult, and the chances of effecting change are greatly reduced.

A system must address:
- ***child safety,***
- ***child well-being,***
- ***family preservation.***

A "community-based" philosophy assumes that a diverse and inclusive set of community members will be stakeholders in creating a network of services that are responsive to needs of local families. Community members in such a system would agree to share the responsibility for protecting children, and some would personally volunteer their time to provide support to families at high risk of abuse and neglect.

A community system must be responsive to the demographics of the families it serves—racial and ethnic heritage, language, family structure, income, and housing. Services must be tailored for single-parent families; multigenerational families; low-income families; multilingual families; blended families of step-parents, half-siblings, and relatives; and mixed racial families. It also means that services are located nearby, are open during appropriate hours, and are culturally compatible with the area. Within such a community system, "safety" must not be limited to the prevention of child fatalities. It must include the child's nutrition, safe housing, and preventive medical care, as well as community safety from crime and violence.

A community system must be responsive to racial and ethnic heritage, language, family structure, income and housing.

When community-based supports are available on an accessible and flexible basis, and a viable child protection system is operating, we believe most families will use and benefit from such a system, and serious and fatal injuries from child abuse and neglect will be reduced.

Increasing the Emphasis on Family Support Services

Clearly the most effective way to stop fatalities is to prevent high-risk behavior in the first place. Support services are based on a philosophy of lending families a helping hand *well before* they need CPS. As Family Support programs become more widespread, we urge policymakers to find ways to actively draw in those families whose multiple needs could one day put them at risk for abuse or neglect.

Reaching Fathers and Other Males

"In the Oklahoma shaken baby data, we found that the largest number were killed by men acting alone. But as you know, most of our prevention effort on Shaken Baby Syndrome is with mothers." —Dr. Barbara Bonner, Center on Child Abuse and Neglect, University of Oklahoma, New York Focus group, 1994

There is no easy way to reach fathers, male companions, or stepfathers. Even hospital-based, new parent intervention programs face tremendous difficulties identifying and involving fathers, who all too often are not even named on birth certificates.

Public education campaigns are one obvious way to inform new parents, including males. But males must somehow be pinpointed for education and intervention. We are recommending several innovative approaches (see Recommendation 23).

One such place to reach males is in prison. Programs may help incarcerated men address their violent behavior and learn ways to control their anger toward others. We urge policymakers to put their best thinking to work on this all-important effort.

ONE PROMISING INNOVATION:

A grant from the Administration for Children and Families (ACF) in the Department of Health and Human Services (DHHS) is allowing the California Youth Authority prison system to launch a positive parenting training program for young incarcerated fathers. Young Men as Fathers is being implemented in four institutions to attempt to demonstrate that child abuse and neglect can be reduced among children of men at high risk for perpetrating abuse and neglect.—Young Men as Fathers: Positive Parting for Incarcerated Fathers. Grant No. 90-CA-1502.

Getting the Private and Nonprofit Sectors Involved in Prevention

This Board urges far more corporate and foundation involvement in fighting fatal abuse and neglect, such as distributing educational information with diapers, bottles, or other products for infants and toddlers; creating public service announcements about the warnings signs of abuse and neglect and ways to report it; and funding public prevention campaigns.

National campaigns, such as those sponsored by the NCPCA and the American Media Council on Child Abuse and Neglect, can awaken the nation to child abuse and neglect. Media efforts, such as KABC-TV Los Angeles' year-long campaign on fatal child abuse prevention, have engaged entire communities in prevention efforts. Public messages, such as the wisdom of counting to 10 when angry, or what to do in a grocery store when one suspects a child is being abused by a parent, should be tested experimentally to determine the best means of influencing the intended population.

Campaigns, such as those sponsored by NCPCA, KABC-TV Los Angeles and the American Media Council on Child Abuse, have engaged entire communities in prevention efforts.

One recent corporate example has been set by the NCPCA and Ertel Co., manufacturer of Jibba Jabber, a fantasy doll with a long neck that squeaks when shaken. When told about Shaken Baby Syndrome, the company voluntarily worked with the NCPCA to place an insert in Jibba Jabber packaging explaining that while Jibba Jabber is for fun, a lethal form of child abuse involves the shaking of babies. The pamphlet lists seven ways to react positively to a child rather than resorting to violence.

ONE FOUNDATION SPREADS THE WORD:

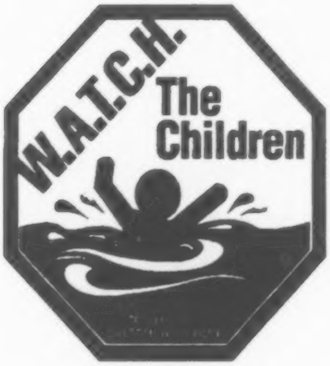
Many groups have launched public service campaigns to teach basic messages and overcome widespread ignorance among high-risk parents about threats to children. The Children's Trust Fund is educating the public about Shaken Baby Syndrome, and is erecting a monument in Texas dedicated to children who have died of abuse and neglect, with the hope of increasing societal awareness.—Mary Alice Brown, Manager of Research and Evaluation, Children's Trust Fund, Dallas Hearing, 1994.

Reducing Preventable Deaths from Household Hazards

Thousands of children are killed and disabled each year by preventable accidents and intentional attacks involving common environmental hazards. Recent research by Phillip Hyden has shown that 1,300 children up to age 18 die from building fires, scald burns, and other burns each year, while 4,000 are disabled—sometimes horribly so (verbal testimony, 1994). Scald injuries, which cause the most hospitalizations, are overwhelmingly blamed on excessively hot tap water. Emergency room workers and coroners see too many severe immersion scald burns on infants and very small children, accidentally or purposefully inflicted by parents and caretakers with easy access to needlessly hot tap water. A simple product is on the market that prevents the water from heating to a dangerous temperature. This device, if routinely installed, could reduce the number of abuse and neglect cases and accidental deaths from scalding.

Another device that could save lives is the quick-release safety latch. Some cities require that homes with barred windows have latches, removable from the inside, so that children and others are not trapped in burning buildings, a tragedy that is reported every week somewhere in the

United States. It is now up to communities to mandate such safeguards. Other cities have initiated drowning prevention campaigns that have resulted in an increase in public awareness and in the passage of ordinances requiring barrier fencing and other structural safeguards to reduce the number of toddler drownings. Thus, simple, inexpensive devices can do much to save children's lives.



Los Angeles County Fire Department
1995 Drowning Prevention Campaign

CHAPTER FOUR RECOMMENDATIONS

In Chapter One, our Recommendations addressed the widespread lack of knowledge and insufficient information that badly hampers our ability to prevent fatal child abuse and neglect. In Chapter Two, our Recommendations furthered our philosophy of better educating professionals to identify abuse and neglect and of holding perpetrators responsible for child deaths. In Chapter Three, our Recommendations emphasized the critical importance of Child Death Review Teams in assessing fatalities, pinpointing system flaws, and promoting prevention.

In this fourth and final Chapter, we are urging the creation of reasonable, positive services for families in need of help and suggesting a design for primary prevention that stresses child and family well-being in a healthier, more active, community-based setting. We are pinpointing the populations at greatest risk for becoming victims of serious and fatal abuse and neglect—very young children—as well as those at greatest risk for becoming perpetrators—male caretakers and parents of toddlers and infants. We are emphasizing the urgent need for private and foundation involvement in public awareness campaigns. And we are urging that when a family completely fails a child, that child be given a second chance with a new life and a new family in an expeditious manner. We, therefore, recommend:

Recommendation 16: All child and family programs must adopt child safety as a major priority.

Family, child welfare, health, mental health, and education programs must adopt children's safety as a major priority and explicitly assess the child's safety while providing services. But their goals must also include the child's overall well-being and development and the preservation of the family, as long as the safety and well-being of family members can be provided for.

Recommendation 17: All relevant State and Federal legislation must explicitly identify child safety as a goal.

To avoid any confusion as to whether other goals override child safety, Congress and State legislatures, when considering future Federal or State legislation regarding programs for families and children or reauthorizing legislation, must explicitly identify child safety as a major goal. This goal must be statutorily presented as consistent with other public policy goals such as family preservation and permanence for children.

Recommendation 18: The decision to remove children from their homes or initiate family preservation services should be made by a team.

Child protection and law enforcement agencies, when deciding whether to initiate family preservation services or to remove a child from the parental home, should use multidisciplinary team assessment and decision making whenever possible. Such agencies should never allow such a decision to be made by one person alone. Except in emergency cases, these decisions should never be made by only one person.

Recommendation 19: Family preservation services should be available in every jurisdiction.

Whenever removal of a child is being considered by CPS, law enforcement, or a juvenile court, intensive family preservation services, as previously described in this chapter, should be viable enough so that they should be available to every jurisdiction as an option.

Recommendation 20: States should follow guidelines when considering family preservation services.

Until the completion of badly needed research on the families most likely to be helped by family preservation services, States should use the following guidelines in determining whether family preservation services are the appropriate option for a specific family:

- The decision to use family preservation services within the parental home should be made in the context of ongoing assessment of risk to the child's safety and of the family's commitment and willingness to participate in the program.

- The safety and well-being of the children must be the priority in the selection of family preservation (or any other) service program for families and children.

- Family preservation services should be utilized only when the professionals most familiar with the family situation, particularly those in the CPS agency, are professionally comfortable with the use of those services. No agency should have policies that result in what is essentially mandatory use of family preservation services.

- Family preservation service providers should both anticipate a positive result from the provision of services and be comfortable with the safety of the child in the home before agreeing to initiate services. Public agency contracts with service providers must include protections against agencies having to accept inappropriate referrals in order to maintain their fiscal solvency.

- After the death of a child due to parental abuse or neglect or after egregious abuse or neglect, surviving children must not be left in the home with or under the care of the perpetrator of the abuse.

- The decision to utilize family preservation services should focus on the extent of the abusive or neglectful behavior, the parent's willingness to be an active participant in services, the risk to the child's safety presented by conditions in the home, and the frequency and duration of contact with the family by community service agencies.

- Family preservation services cannot be effective if the parent(s) is so affected by disabling substance abuse, mental retardation, or untreated mental illness that she/he cannot participate in the service delivery program.

- If domestic violence is a pattern in the home, there must be sufficient protection provided to family members and to family preservation staff to assure that services are safe and effective.

(The Board notes that the American Professional Society on the Abuse of Children (APSAC) has established a committee to develop standards for the appropriate use of family preservation services, and the Board looks forward to the contribution their efforts will make).

Recommendation 21: An array of primary prevention services and supports, including home visiting, must be made available to all families.

Primary prevention means helping families before an incident of abuse or neglect occurs. Available Federal funds from the Family Preservation and Family Support Act, CAPTA, and Title IV-B should be provided with flexibility to the States for implementation, integration, and evaluation of comprehensive primary prevention services. Services should be provided using an interdisciplinary, multiagency approach in conjunction with existing primary prevention efforts.

Because it is impossible to predict which families will kill their children, the most effective prevention is to support parents in being effective and nurturing, to provide treatment services when family problems do arise, and to respond quickly and appropriately when abuse or neglect is identified. To accomplish this, each community should make available to families a comprehensive array of supportive programs, resources, and social services.

This Board particularly emphasizes the need for:

- Voluntary home visiting provided to all expectant and new parents.
- Substance abuse treatment programs, particularly for pregnant women and parents at risk of abusing or neglecting their children.
- Drop-in child care and respite care programs, particularly for parents with fragile or nonexistent natural support systems and parents of children with disabilities.
- Parent education programs focusing on the healthy development of children.
- In addition, we recommend:
- Parenting preparation programs in elementary and secondary schools that emphasize ways of dealing with stress, coping with conflict and aggression, and positive methods of discipline.
- Family recreation facilities, resource centers, and drop-in centers.

Recommendation 22: Family support services funding should be used for prevention programs aimed at families of infants and toddlers.

Because most children die from abuse or neglect before age 4, available Family Support funds and other prevention funds should be used to significantly increase the emphasis on mothers, fathers, and other caretakers of infants, toddlers, and preschoolers.

Such families, particularly those whose situations and needs put them at high risk of abuse or neglect, should receive services through prenatal and postnatal programs, as well as WIC and day care programs. Parents of older children may be reached through Headstart.

Recommendation 23: States and local agencies should design prevention programs for men. Programs should also integrate services and training on child abuse and domestic violence.

The longtime targeting of prevention programs toward women has created a dramatic gap in critical interventions and other services available for men. Reports indicate males, acting alone or together with women, are responsible for many child deaths due to abuse and some of deaths by neglect. Specific strategies must reach men and alert women to the potential role of men in abuse, and should be funded with Federal Family Preservation and Support monies, as well as public and private sources at the State and local level.

Because of the correlation and frequent coexistence of domestic violence and child abuse, programs should address all forms of family violence, especially when small children are in the home.

Strategies could include, but should not be limited to:

- Parent "mentoring" that involves fathers at baby's birth.
- Hospital-based education of new fathers on coping with "triggers" of violence.
- Preventive education programs for prison-based males, a population marked by low-income, substance abuse and other correlates closely associated with child abuse and neglect.

- Domestic violence programs that recognize that adults who abuse a spouse or partner are also at high risk of abusing a child.

- School programs designed specifically to educate children about male roles in parenting.

Recommendation 24: Expedited termination of parental rights should be developed in every State.

When voluntary relinquishment is not an option, CPS, States, and the juvenile courts should develop ways to expedite court TPR and placement with a permanent substitute family when a child cannot safely remain with or return to parental custody. Federal laws do not require long, unreasonable efforts to preserve unsalvageable families, but most States currently lack specific guidelines regarding when to seek TPR and methods of expediting this legal process. Therefore:

- States, assisted by the ABA and the National Council on Family and Juvenile Court Judges (NCFJCJ), should adopt guidelines for CPS agencies and prosecuting attorneys representing CPS agencies to use in determining when to file TPR and seek permanent placement of children with adoptive families.

- States, with assistance from ABA and NCFJCJ, should develop legislation providing juvenile courts with procedures to streamline the TPR process to reduce court procedural delays that now may add years of foster care for children awaiting a permanent family. Court improvement grants available from the Family Preservation and Family Support Services Program should be used to help implement strategies for reducing such delays.

Recommendation 25: A broad public prevention campaign should be developed to address serious and fatal child abuse and neglect.

Well-constructed campaigns can help educate parents about the triggers associated with serious injury and deaths of infants and children and suggest alternatives to cope with such problems. Such campaigns can substantially increase public awareness with regard to reporting abuse and how to prevent harm to children.

The media should play a major role in this effort because of their unique ability to reach into homes of millions of people, including those who need help and those who might help others. Campaigns should be sensitively created and culturally and linguistically appropriate, producing material parents are likely to see or read rather than information presented in a way that alienates. However, "shock value" campaigns such as California's antismoking effort should also be included.

These efforts should be spearheaded by the Department of Health and Human Services (DHHS) and other Federal, State, and local agencies and sponsored by communities, the private sector, foundations, and the media.

Campaigns should include:

- Warnings to parents about "triggers" associated with parental violence toward children, such as inconsolable crying and difficulties of toilet training.
- Informing parents how they can prevent deaths and serious injuries, such as bathtub drownings, drownings in 5-gallon buckets, and poisonings.
- Voluntary involvement by major manufacturers, such as diaper and baby bottle companies, to print information on their products that educate parents about the natural developments and setbacks they should expect in toilet training and feeding.

Recommendation 26: Regulatory measures should be adopted to reduce environmental dangers.

Regulations and codes should be enacted to end preventable child fatalities and serious injuries from household hazards and environmental dangers. State legislatures and local governments should enact laws, building codes, or regulations to:

- Require heat regulators on hot water faucets in new residential construction to prevent severe or fatal scalding injuries of young children.
- Require door locks and fencing directly adjacent to yard swimming pools to prevent drownings of children due to accidents or lack of supervision.

- Require window guards with safety latches in multilevel and high-rise buildings where children are likely to reside.
- Promote public awareness of the dangers of toddlers drowning in accessible buckets of water due to their "top heavy" center of gravity and the need for smoke alarms and other fire safety measures.

CONCLUSION: THE CHALLENGE

With this report, we call upon Congress, the Administration, States, communities, child advocates, and the media to take actions to address the crisis of children dying from abuse and neglect. Our Nation has a responsibility to make the health, well-being, and very survival of children a national priority. This report contains 26 Recommendations aimed at preserving children's lives. We urge that these Recommendations be considered carefully, be fully discussed, and then embraced by America's decisionmakers. By taking decisive action now, we can begin to shape a future that ensures the health and safety of our Nation's children.

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EPILOGUE

In June 1994, Board members met with the members of the Family Violence Program, at the Bedford Hills Correctional Facility to discuss the impact of the child protection system and social services upon their experience as abused children and as perpetrators of abuse. Board members and the Bedford Hills staff discussed the problems of current prevention services with the program members.

Most of the women were victims of tremendous violence and extreme family chaos throughout their lives. Ultimately, these victims became violent victimizers, involved in destructive relationships, lashing out at their children and others, and eventually committing the crimes of which they are convicted. Their desire to understand the role of violence in their lives has led them to join the Family Violence Program.

The eloquent written and oral testimony of the women in the Family Violence Program reaffirmed the need for comprehensive services for children and parents in the child protection system. All the women had great insight into the failure of "the system" throughout their lives and the need to improve the protection of children.

Here are two stories, in the words of the women, of their journeys:

Speaker A:

"My terror and rage led to the death of my 6-week-old son. I make no excuses for my acts. What I share with you is an effort to understand myself and others, and perhaps in some way to find even a small degree of forgiveness in myself.

What I want this Board to know is two things: first, that my son's death was tragic; and, second, that it was not until a series of investigations of the events that any meaningful intervention worked for the rest of my five children.

My husband first had sex with me when I was 4 years old, and later he had sex with me and my children. My life and my children's lives have always been hard. On the day my son died, I had gone to a place where I was high on pills and alcohol at least 80 percent of the time. I was disgusted with everything and furious. The more I drank, the angrier I got.

In my craziness that day, I was trying to run away from my husband with my children. The baby's zipper got stuck. I was panicking because I thought he was coming home, and when my son cried, I struck him. I was so out of control I didn't even realize he was dead. He was quiet. I dressed him and put all the kids in the car and started driving around.

I attempted to kill us all by driving over an embankment into Sheepshead Bay. All I succeeded in doing was banging up the car, and my husband found us. I was never arrested for the death of my son or charged, but my husband and I were later charged with and found guilty of sexual abuse. The irony is that they thought my son died as a result of whiplash.

I share these things with you because I deeply know that things have to change. At times I am bitter because there were no interventions for me as a child. I was tortured physically and sexually for as long as I can remember. I never knew what normal was or could be. I am a woman and a mother who hurts deeply inside, but I am not a monster. I am a hurting soul. I have a wounded soul, and perhaps the deepest pain is that I became just like all of those people in my life that tortured me."

Speaker B:

"It was winter, and for 4-1/2 years of my marriage the abuse escalated. About the time my son was born, 1-1/2 years into the marriage, the abuse became physical. There were words, fists, threats, silence, and isolation.

I lived in constant fear and was always anticipating and trying to avoid the next beating. By the time my daughter was born, it was a nightmare. When she would cry, he constantly threatened that I had better shut her up, and that she had better go to sleep. The baby cried and continued to cry. His hollering, my fear, the craziness of our lives. How could a baby sleep?

I was desperate. I didn't think I wanted to end her life. I only wanted her to be quiet. I'm not sure how sane I was at that point. I have questioned that every year of my imprisonment. I've wondered what his abuse, the postpartum issues also played in my insanity. His threats got severe. They got worse. And the beatings increased. My wrist was broken. He damaged my right eye. He cracked one of my ribs. The bruises, the fear, the terror.

All I know was that somehow I focused on the baby. If only I could get her to quiet down. Every whimper from the baby would send me into a panic, trying to calm her to avoid his anger. But I was angry, terribly angry, and knew her crying was angering him. I was terrified and angry.

I gave her some formula, and I put something in it. I thought it would just help to quiet her down. But what I really did was poison her. When I discovered her quiet in the crib and having difficulty breathing, I took her to the hospital. She was very quiet, and I was very scared. I have relived over and over again the memories of putting that poison in her bottle, and the fact that I killed my innocent child.

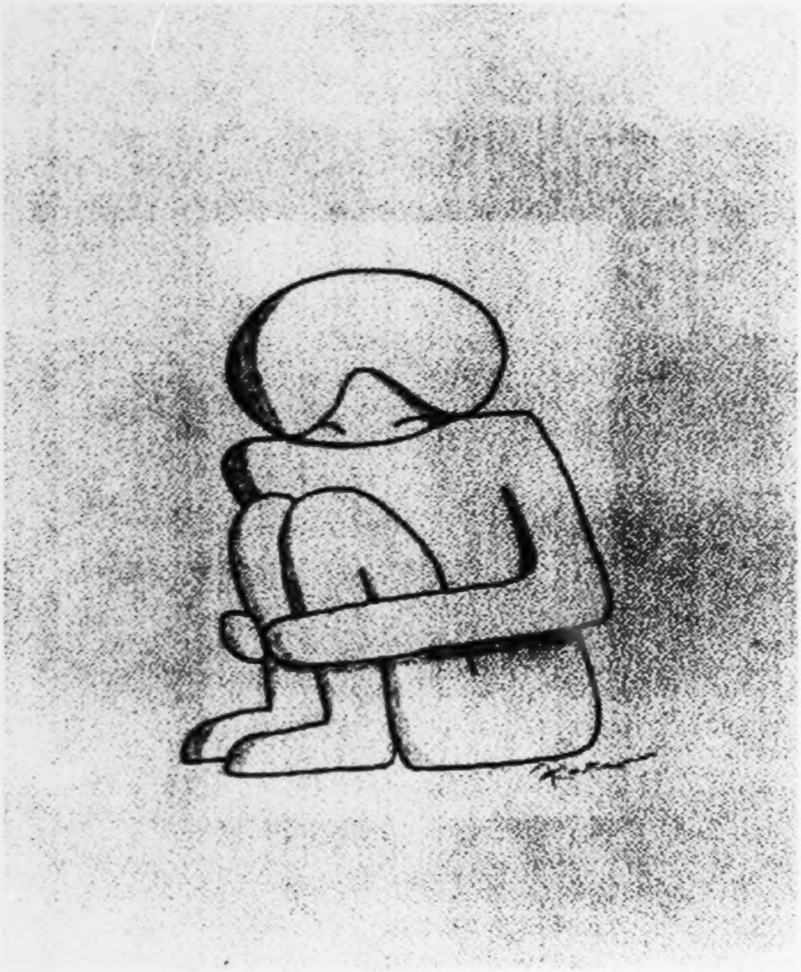
When I was sentenced, my husband said to me, you shut her up, and now no one will hear you because you are going to prison."

The Family Violence Program at the Bedford Hills Correctional Facility is an outgrowth of a hearing held at the prison in 1985 on the relationship between incarcerated women and domestic violence. The program began in 1987 through funding and support provided by the New York State Department of Correctional Services and the Women's Division of the Governor's Office. The goal of the program is to provide women with a safe and supportive environment in which they can begin to identify and address experiences of violence and victimization in their lives.

The program currently has 150 participants, with a waiting list of 60. Women come to the program voluntarily and must participate in an 8-week orientation to become a member. The program's membership represents a variety of socioeconomic classes and ethnic groups. The Family Violence Program has included women who are African American, Hispanic, Latino, White, Jamaican, Colombian, Albanian, Chinese, Greek, and American Indian. Many of the women have obtained high school diplomas, as well as bachelors' and masters' degrees while incarcerated.

The program offers traditional and nontraditional forms of individual and group therapy for the participants. Besides therapy, the participants are also active in community outreach. Members have worked with domestic violence centers and the Governor's Office to educate the public about family violence. Program members have produced and edited a film called ***We Are Not Who You Think We Are.*** *The film depicts the connection between victimization and drug use and recently received the Bronze Apple Award from the National Education Association.*

The Family Violence Program is the only program of its kind in the country.



Kate—Special Education Division
New School for Child Development

U.S. ADVISORY BOARD MEMBERS

In accordance with the provisions of the 1988 Amendment to the Child Abuse Prevention and Treatment Act (CAPTA), the U.S. Advisory Board on Child Abuse and Neglect (ABCAN) comprises 15 members, each of which "is recognized for expertise in an aspect of the area of child abuse." Of the 15 members, 2 are Federal employees who are also members of the Inter-Agency Task Force on Child Abuse and Neglect; and 13 members represent the general public.

Following is a list of the current Board members. Each entry includes the beginning and ending dates of a member's term of appointment and specific expertise mandated by statute that a member brings to the Board.

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Term Ending: May 29, 1996

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Term Ending: May 29, 1996

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HEARING ON CHILD MALTREATMENT-RELATED FATALITIES
APRIL 3, 1992

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MINI HEARING ON RELIGIOUS EXEMPTION
MAY 26, 1993

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HEARING ON CHILD MALTREATMENT-RELATED FATALITIES
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HEARING ON CHILD-MALTREATMENT FATALITIES
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HEARING ON CHILD MALTREATMENT-RELATED FATALITIES
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AND
HEARING ON CHILD MALTREATMENT-RELATED FATALITIES
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JULY 21 - 22, 1994

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HEARING ON CHILD MALTREATMENT-RELATED FATALITIES
AUGUST 1, 1994

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This hearing took place during the National Symposium on Child Fatalities, *The Missouri Experience*, sponsored by the Missouri Department of Social Services.

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HEARING ON CHILD MALTREATMENT-RELATED FATALITIES
AUGUST 30, 1994

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This hearing took place in conjunction with the 1994 Crimes Against Children Seminar sponsored by the Dallas Police Department and the Dallas Children's Advocacy Center.

REVIEW OF CHILD FATALITIES RESEARCH AND LITERATURE

compiled by
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The literature review for this study involved a systematic computer search of the following databases: PsychLIT, Medline, and the University of New York (SUNY) at Buffalo's Bison index. The search used key terms such as child maltreatment, fatality, homicide, severe, abuse, neglect, and any derivatives or variations of those terms. In addition to the computer search, bibliographies of relevant articles were reviewed for citations of important earlier research. Searches included current research and articles dating up to 20 years prior to the release of this report. Finally, the authors also reviewed several State and Federal reports on child fatalities as well as documents of testimony given at various U.S. Advisory Board on Child Abuse and Neglect conferences on child fatalities.

Childhood Homicide

Abel, E.L. (1986). Childhood homicide in Erie County, New York. Pediatrics, 77(5), 709–713.

Childhood homicide during 1972 to 1984 constituted 7.6 percent of the total homicides in Erie County, N.Y., a relatively higher percentage than for the United States as a whole. Notably, the age-specific rate for African American children less than 4 years of age was 17.9 per 100,000, a rate higher than that for Northern Ireland. In addition to child's age and race, this study examined various demographic and situational characteristics associated with childhood homicide as an initial step in developing prevention strategies.

Blaser, M.J., Jason, J.M., Weniger, B.G., Elsea, W.R., Finton, R.J., Hanson, R.A., & Feldman, R.A. (1984). Epidemiologic analysis of a cluster of homicides of children in Atlanta. Journal of the American Medical Association, 251(24), 3255–3258.

The authors sought to define the epidemiologic characteristics of a cluster of unsolved child homicides and disappearances in Atlanta and to determine whether there were identifiable factors associated with increased risk of homicide.

Christoffel, K.K. (1984). Homicide in childhood: A public health problem in need of attention. American Journal of Public Health, 74, 68–70.

Based on children's changing developmental vulnerabilities, it is possible to characterize three subtypes of child homicide—infanticide, fatal child abuse and neglect after infancy, and homicide in the community. Specific approaches to primary prevention include measures to strengthen families and their community support systems and to educate adults and children concerning appropriate behaviors of children at different ages.

Christoffel, K.K. (1990). Violent death and injury in U.S. children and adolescents. American Journal of Diseases of Children, 144, 697–706.

This article reviews what is known about violent injury to US children and adolescents aged 0 to 19 years and presents data for 1985. The violent injuries addressed include child abuse and neglect (maltreatment by responsible adults); assault (by persons—strangers, peers, or others- not responsible for the victim); and homicide (death due to child abuse and neglect or assault).

Christoffel, K.K., Anzinger, N.K., & Amari, M. (1983). Homicide in childhood- distinguishable patterns of risk related to developmental levels of victims. The American Journal of Forensic Medicine and Pathology, 4(2), 129–137.

A review was done of the 29 medical examiner-autopsied children under 10 years of age who died under suspicious circumstances in Cook County, IL, in the first half of 1981. Variables including age of victim, family composition, socioeconomic status, ethnicity, and type of death were examined. The data suggest that there are three clinically distinguishable types of homicide in childhood—infanticide, fatal child abuse and neglect after infancy, and murder in the community—related to developmental characteristics of the victims.

Christoffel, K.K., Anzinger, N.K., & Merrill, D.A. (1989). Age-related patterns of violent death, Cook County, Illinois, 1977–1982. American Journal of Diseases of Children, 143, 1403-1409.

To clarify age-related patterns of violent death in childhood, a study was undertaken of medical examiner records concerning 437 deaths of Cook County, IL residents, younger than 15, who died from 1977 through 1982, and whose deaths were ruled as homicides or of an undetermined manner. African American children were overrepresented. Parents were usually perpetrators for victims younger than age 5 and others for victims older than age 5. Different circumstances of death characterized victims who were younger and older, and incidence was associated with urban residence and poverty as well as youngest and oldest age groups.

Copeland, A.R. (1985). Homicide in childhood: The Metro-Dade County experience from 1956 to 1982. The American Journal of Forensic Medicine and Pathology, 6(1), 21–24.

This study is concerned with all homicides in Metro-Dade County in victims 12 years of age or less during the 27-year period from 1956 to 1982. Cases were readily subdivided into two groups—those exhibiting child abuse and those that did not. These two groups were further characterized by age, race, sex, cause of death of victim, and perpetrator fatal act. It was apparent that not all childhood homicides involved child abuse.

Crittenden, P.M. & Craig, S.E. (1990). Developmental trends in the nature of child homicide. Journal of Interpersonal Violence, 5(2), 202-216.

Citing a need to identify a coherent pattern or set of patterns among cases of childhood homicide, this study differentiated among neonatal, early, and middle childhood deaths. The authors looked carefully at types and circumstances of deaths in reference to child age. They conclude that it is difficult, or even impossible, to identify preventively specific cases of incipient homicide.

Goetting, A. (1990). Child victims of homicide: A portrait of their killers and the circumstances of their deaths. Violence and Victims, 5(4), 287–296.

The population of 93 arrestees for homicides committed against children between 1982 and 1986 in Detroit, MI, is analyzed in the context of their killings. Analyses include demographic and social relationships between offenders and victims, circumstances of offense, and arrest disposition.

Hollander, N. (1986). Physical abuse as a predictor of child homicide. Texas Medicine, 82, 21–23.

Sequential records of 48 child deaths that occurred from 1979 through 1984 were reviewed to ascertain whether it is possible to predict and prevent child deaths caused by abuse. Information of the cases was available from the Dallas County Child Welfare Department. 25 of the deaths were the result of homicide or undetermined cause, and in 23 of the total deaths reported (92 percent) of these, physical abuse or other physical violence in the home preceded the episode of fatal abuse. Detailed examination of the cases indicates that fatalities could be prevented by considering physical abuse a reason for removing a child from the abusive parent either permanently or until appropriate intervention has occurred.

Jason, J. (1983). Child homicide spectrum. American Journal of Diseases of Children, 137, 578–581.

National homicide data for persons younger than 18 from 1976 through 1979 were used to characterize child homicide. Two broad categories were identified: the first predominates until the victim age of 3 years, is intrafamilial, and is associated with bodily force and poorly defined precipitating events. It can be described as fatal child abuse. The second type predominates after the victim age of 12 years, is extrafamilial, involves guns or knives, occurs during arguments or criminal acts by the offender, and may represent children unsupervised in an adult environment.

Jason, J. (1984). Centers for Disease Control and the epidemiology of violence. Child Abuse and Neglect, 8, 279–283.

The Center for Health Promotion and Education, the Centers for Disease Control (CDC) has begun to apply epidemiologic techniques to study the problems of child abuse, child homicide, homicide, and suicide. This paper discusses an epidemiological investigation of the underrecording of child homicide in the United States.

Jason, J., Gilliand, J.C., & Tyler, C.W. (1983). Homicide as a cause of pediatric mortality in the United States. Pediatrics, 72(2), 191–197.

National law enforcement data from 1976 through 1979 were analyzed to characterize and differentiate neonaticide, infanticide, filicide, and overall child homicide. Analyses include incidence, types of deaths, demographic characteristics of victims and offenders, and victim-specific rates by geographic region. The authors examine the possible role of pediatricians in identifying risk factors for child homicide.

Muscat, J.E. (1988). Characteristics of childhood homicide in Ohio, 1974–1984. American Journal of Public Health, 78(7), 822–824.

Childhood homicide deaths in Ohio from 1974 to 1984 were examined using Ohio Vital Statistics records and U.S. Census Data. Homicide rates varied from 25/100,000 for African American infant males to 0.8/100,000 for white females ages 5–9. Child battering was the leading cause of death for children under 5 years of age. Firearms accounted for a large percentage of deaths for children 10–14 years of age. Childhood homicide was associated with low socioeconomic indicators in the four largest Ohio cities.

Paulson, J.A. & Rushforth, N.B. (1986). Violent death in children in a metropolitan county: Changing patterns of homicide 1958-1982. Pediatrics, 78(6), 1013–1020.

Data from the Cuyahoga County, OH, coroner's office pertaining to homicides in children younger than age 15 between 1958 and 1982 were analyzed. Findings indicate fatal child abuse in younger children and deaths attributed to community violence in older children. Homicide rates increased in the first 20 years and then stabilized. Nonwhite males had the highest death rate except in one period. Assailants were usually adolescents and young men, however, 43 percent of children under age 5 were killed by women. Firearms were the leading cause of homicide.

Fatal Child Maltreatment

Anderson, R., Ambrosino, R., Valentine, D., & Lauderdale, M. (1983). Child deaths attributed to abuse and neglect: An empirical study. Children and Youth Services Review, 5, 75-89.

This study of 267 child deaths associated with abuse or neglect in Texas during 1975 through 1977 suggests a number of indicators for identifying potential child fatalities. Families where abuse or neglect is implicated in a child fatality are characterized by small family size, young parents, and underutilization of community support services.

Alfaro, J.D. (1988). What can we learn from child abuse fatalities? A synthesis of nine studies. In Besharov, D. Protecting Children From Abuse and Neglect. Springfield, IL: Charles C Thomas, Publisher.

This synthesis report examines the methods and results of recent child maltreatmentfatality studies. It focuses on nine studies that have examined maltreatment fatalities from the child protective service perspective. The methods of these studies vary, making the comparability of their data uncertain, but they have a common purpose—to improve one or more aspects of the child protection system.

Bergman, A.B., Larsen, R.M., & Mueller, B.A. (1986). Changing spectrum of serious child abuse. Pediatrics, 77, 113—116.

To determine whether the spectrum of serious child abuse has changed over the past decade, hospital and medical examiner records in the Seattle area were reviewed for the years 1971 to 1973 and 1981 to 1983. Although the incidence of hospitalized cases was similar in the two time periods, the proportion of severe injuries that occurred increased significantly.

Christoffel, K.K., Zieserl, E.J., & Chiaramonte, J. (1985). Should child abuse and neglect be considered when a child dies unexpectedly? American Journal of Diseases of Children, 139, 876–880.

Deaths during 2 years at a pediatric teaching hospital were studied to develop guidelines for clinicians who must decide when to explore the possibility of child abuse or neglect when a child dies unexpectedly. The two factors "dead on arrival" and "1 year of age or less" identify a high-risk group requiring at least hospital-based investigation into the possibility of abuse or neglect. Reporting for suspected child abuse and neglect is warranted when (1) unsuspected trauma is found post mortem, (2) there is direct physical or social evidence of child abuse or neglect, or (3) the child is in the high-risk group and hospital-based investigation fails to eliminate the possibility that maltreatment contributed to the child's death.

Durfee, M. (1989). Fatal child abuse -intervention and prevention. Protecting Children, 9–12.

An overview of the problem of fatal child abuse explains the role of a multiagency, multidisciplinary case review team in bringing order to intervention and prevention of such deaths.

Jason, J. & Andereck, N.D. (1983). Fatal child abuse in Georgia: The epidemiology of severe physical child abuse. Child Abuse & Neglect,7, 1–9.

Fifty-one fatal child abuse cases occurring in Georgia between July 1975 and December 1979 were compared with nonfatal cases and to the Georgia population. Overall rates of fatal child abuse were higher for male perpetrators compared with female and black perpetrators compared with white. The highest child abuse fatality rates were found in poor, rural, white families and in poor, urban, black families. Risk factors for fatal abuse included early childhood, parental teenage childbearing, and low socioeconomic status.

Krugman, R.D. (1985). Fatal child abuse: Analysis of 24 cases. Pediatrician, 12, 68–72.

Analysis of 24 cases of fatal child abuse reveals that multidisciplinary review can assist in the determination of whether fatal injury was accidental or non-accidental. All cases had both a 'discrepant history' and some 'delay' in seeking care. The predisposing child factor was inconsolable crying in infants under 12 months, and was associated with a bowel or bladder accident or diaper change in 9 of 12 cases where children were over 1 year of age. Head injury accounted for 17 of the 24 deaths.

Margolin, L. (1990). Fatal child neglect. Child Welfare, 69, 309-319.

This study examined the circumstances associated with fatal child neglect in one state to differentiate fatal child neglect from fatal physical abuse and from other types of neglect that are not life-threatening. The typical neglect fatality was a male child, younger than three, living with his mother and two or three siblings.

McClain, P.W., Sacks, J.J., Ewigman, B.G., Smith, S.M., Mercy, J.A., & Sniezek, J.E. (1994). Geographic patterns of fatal abuse or neglect in children younger than 5 years old, United States, 1979 to 1988. Archives of Pediatrics & Adolescent Medicine, 148, 82-86.

This study used a death certificate-based model to estimate the occurrence of fatal child abuse and nelgect and to examine geographic patterns of fatal child abuse and neglect among children younger than 5 in the United States between 1979 and 1988. The authors estimate that from 868 to 1815 deaths from child abuse and neglect annually occur among this population and that death rates were higher in the South and West, intermediate in the North and Central States, and lowest in the Northeast.

McClain, P.W., Sacks, J.J., Froehlke, R.G., & Ewigman, B.G. (1993). Estimates of fatal child abuse and neglect, United States, 1979 through 1988. Pediatrics, 91, 338–343.

This study explored the use of death certificate data to estimate the number of fatalities due to child abuse or neglect in the United States among children 0 through 17 for 1979 through 1988. After formulating 3 models, for the 10-year period, the estimated mean annual child abuse and neglect fatalities ranged from 861 to 1,814 for ages 0 through 4 and from 949 to 2022 for ages 0 through 17. It is concluded that the magnitude of fatal child abuse and neglect can be estimated from death certificates, but that the death coding system should be modified to make identification of child abuse and neglect fatalities easier.

McCurdy, K. & Daro, D. (1994). Child maltreatment: A national survey of reports and fatalities. Journal of Interpersonal Violence, 9, 75–94.

This article examines the scope of the child maltreatment problem in the United States. Representatives of child protective service agencies in each state and the District of Columbia were interviewed to obtain current estimates of child maltreatment reports and fatalities. The results of the survey indicate that rates of reported and substantiated cases of child maltreatment as well as confirmed child deaths due to abuse or neglect have steadily increased over the past 8 years. Evidence shows that very young children face the greatest risk of dying from maltreatment.

Sabotta, E.E. & Davis, R.L. (1992). Fatality after report to a child abuse registry in Washington State, 1973-1986. Child Abuse & Neglect, 16, 627–635.

For 11,085 children born in Washington State between 1973 and 1986 and reported to the State child abuse registry, authors analyzed the fatality rate subsequent to reported abuse and compared it to a population of nonabused children matched on sex, county of birth, and year of birth. Children reported to the child abuse registry had an almost threefold greater risk of death than the comparison population.

Zumwalt, R.E. & Hirsch, C.S. (1980). Subtle fatal child abuse. Human Pathology, 11, 167–174.

The authors present six instances of fatal child abuse that illustrate the types of unusual physical and chemical assault and the covert negligence that kill children. Unfamiliarity with the law, lack of suspicion in approaching cases, and failure to utilize necessary techniques to establish the mechanism of death can obscure recognition of the homicidal nature of such fatalities.

Investigating Child Fatalities

Durfee, M.J., Gellert, G.A., & Tilton-Durfee, D. (1992). Origins and clinical relevance of child death review teams. Journal of the American Medical Association, 267, 3172–3175.

This article provides an introduction to the unique factors and magnitude of suspicious child deaths and to the concept and process of interagency child death review.

Helpern, M. (1976). Fatalities from child abuse and neglect: Responsibility of the medical examiner and coroner. Pediatric Annals, 41–57.

The author discusses the responsibilities of a coroner and of a medical examiner and emphasizes the difficulties involved in determining the true cause of death. Case examples are provided.

Lundstrom, M. & Sharpe, R. (1991). Getting away with murder. Public Welfare, summer, 18-29.

Adapted from a four part series published by Gannett News Services, this article includes and examples of misclassification of maltreatment fatalities and discussion of factors involved in the investigation process.

Schloesser, P., Pierpont, J. & Poertner, J. (1992). Active surveillance of child abuse fatalities. Child Abuse & Neglect, 16, 3–10.

Birth and death certificates were correlated with information in the State Child Abuse and Neglect Registry on 104 abuse-related fatalities. Significant findings include: very young age of parents at the first pregnancy; high rate of single parenthood; significantly lower educational achievement of victims' mothers; late, inadequate prenatal care; complications during pregnancy; and low birth weight among victims.

Stangler, G.J., Kivlahan, C., & Knipp, M.J. (1991). How can we tell when a child dies from abuse? Public Welfare, fall, 5–11.

Authors offer a synopsis of how Missouri is proceeding to determine whether fatal child abuse is accidental or intentional. This report also includes findings and circumstances leading to the establishment of Missouri's death review teams.

Severe Physical Abuse

Johnson, C.F., & Showers, J. (1985). Injury variables in child abuse. Child Abuse & Neglect, 9, 207–215.

The child abuse reporting records of 616 children seen by the child abuse team in a metropolitan Ohio children's hospital were analyzed. Variables examined include: victim gender, victim race, victim sex, perpetrator relationship, type of injury, injury site, and type of instrument used.

Friedman, S.B., & Morse, C.W. (1974). Child abuse: A five-year follow-up of early case finding in the emergency department. Pediatrics, 54, 404–410.

A total of 156 children under 6 years of age seen for injuries in an emergency department had been previously studied and their injuries were judged by the investigators to represent unreported "suspected abuse," "gross neglect," or an "accident." Five years later, all cases of "suspected abuse" and "neglect," and a random sample of "accidents" were included in a study involving interview of parents and a survey of medical facilities for subsequent contact with these children. At the time of follow up, it was found that children judged to have experienced "accidents" had a lower incidence of subsequent injuries, their siblings had fewer injuries, their relationship to their mother was judged to be better, and there were fewer emotional and social problems in their families.

Hegar, R.L., Zuravin, S.J. & Orme, J.G. (1994). Factors predicting severity of physical child abuse injury: A review of the literature. Journal of Interpersonal Violence, 9, 170–183.

This article reviews the research literature about predictors of severe and fatal physical child abuse, an important question for the design of risk assessment instruments for use at child welfare intake. Of various factors relating to the victim, the perpetrator, and the report of child abuse, the only one found in this review of the literature to relate consistently to severity of injury is the age of the child.

Reece, R.M. (1990). Unusual manifestations of child abuse. Pediatric Clinics of North America, 37, 905–921.

Although the scales have fallen from our eyes when confronted with familiar forms of child maltreatment, instances still exist in which, unless we include child abuse in our differential diagnostic list, the true diagnosis could elude detection. The cases reviewed here represent only a selected few from the literature and from experience but should serve to make the point that things are not always what they seem to be.

Rosenthal, J.A. (1988). Patterns of reported child abuse and neglect. Child Abuse & Neglect, 12, 263–271.

Confirmed reports of abuse and neglect logged in a large state registry file from 1977 to 1984 are analyzed. Boys tend to sustain more frequent and more serious injuries. Victims of male perpetrators tend to sustain more serious injuries. A modest same-sex perpetrator/victim pattern is revealed for physical abuse; males are more likely to physically abuse boys while females are more likely to physically abuse girls. Among younger victims boys outnumber girls in all reporting categories except sexual abuse. Among adolescent victims, female victims greatly outnumber male victims in all reporting categories.

Seaberg, J.R. (1977). Predictors of injury severity in physical child abuse. Journal of Social Service Research, 1, 63–77.

This study is a preliminary examination of factors that might reasonably account for variation in the severity of physical child abuse. If distinctive patterns of such factors can be demonstrated to account for this variation, an empirical basis for typology of physical abuse situations may emerge. Such a typology could provide a basis for developing and testing differential treatment and dispositional modalities.

Showers, J. & Garrison, K. (1988). Burn abuse: A four-year study. The Journal of Trauma, 28, 1581–1583.

Data are presented for 139 children assessed for abuse by burning, and findings are contrasted with previous reports in the literature. The results support assertions that burn abuse is most prevalent among children under 3 years of age and is usually perpetrated by a caretaker who is young, single and poorly educated. The data do not support findings from other studies that boys outnumber girls as victims. Previous reports that immersion burns constitute the major burn type are also contradicted by the present study, and results are examined in terms of sampling techniques.

International Data on Childhood Homicide and Fatal Abuse

Baldwin, J.A. & Oliver, J.E. (1975). Epidemiology and family characteristics of severely-abused children. British Journal of Preventive and Social Medicine, 29, 205–221.

Severe child abuse in Northeast Wiltshire, England, was studied retrospectively during the period 1965 to 1971, and prospectively for 18 months from January 1972, after a period of consultive activity with those actively involved to increase awareness of the phenomenon. An abuse rate of 1 per 1,000 children under 4 years of age was obtained together with a death rate of 0.1 per 1,000. The implications of the ascertainment and death rates are discussed in relation to data from other studies, and the need emphasized for detailed studies of the apparent clustering of disorder in the families, using linked record systems.

Christoffel, K.K. & Liu, K. (1983). Homicide death rates in childhood in 23 developed countries: U.S. rates atypically high. Child Abuse and Neglect, 7, 339–345.

World Health Organization vital statistics data were used to compare U.S. homicide death rates with those in 23 other developed countries. Using rank ordering and comparison with mean and median rates for the other countries, U.S. homicide rates for the general population were found to be exceptionally high. Similarly, U.S. homicide rates for infants and for 1-4 year olds were atypically high. The U.S. infant homicide rate was also characterized by a male predominance.

Christoffel, K.K., Liu, K., & Stamler, J. (1981). Epidemiology of fatal child abuse: International mortality data. Journal of Chronic Diseases, 34, 57–64.

World Health Organization data for 1974 on age-specific death rates due to definite and possible inflicted injuries (DII and PII) in 52 countries were studied. DII death rates for children under age 1 and for all ages were independent internationally. DII death rates for children aged 1 to4 and for all ages were independent in developing countries, but in developed countries came close to correlating. DII death rates were somewhat higher for young children in developed countries and accounted for a greater proportion of deaths in children under 5. Analyses of PII deaths gave less consistent results.

Creighton, S.J. (1985). An epidemiological study of abused children and their families in the United Kingdom between 1977 and 1982. Child Abuse and Neglect, 9, 441–448.

Between 1977 and 1982 there were 6,532 children placed on the child abuse registers maintained by the National Society for the Prevention of Cruelty to Children (NSPCC) in England. This paper examines the data on these children. While the rate of physical injury increased over the time period, the percentage of fatal and serious injuries decreased.

Gartner, R. (1990). The victims of homicide: A temporal and cross-national comparison. American Sociological Review, 55, 92–106.

This paper develops and tests a model of cross-national and temporal variation in homicide rates using sex- and age-specific victimization data from 18 developed nations for the years 1950 to1980. The results indicate that the structural and cultural factors that explain homicide rates in the United States are also associated with sex- and age-specific homicide rates in other countries.

Hargrave, D.R. & Warner, D.P. (1992). A study of child homicide over two decades. Medicine, Science and the Law, 32(3), 247–250.

The child homicides which were notified to the Leeds University Department of Forensic Medicine between 1970 and 1989 were studied. There were 131 cases, and information regarding age of victim, mode of death, and postmortem evidence of previous abuse was noted. Incidence, age of victim, and type of death are examined. Blunt injury accounted for almost half the deaths, and 34 percent of cases showed evidence of previous physical or sexual abuse. Many infant deaths were attributed to "Shaken Baby Syndrome."

Kotch, J.B., Chalmers, D.J., Fanslow, J.L., Marshall, S., & Langley, J.D. (1993). Morbidity and death due to child abuse in New Zealand. Child Abuse and Neglect, 17, 233–247.

The purpose of this study was to explore underdiagnosis and racial bias among child abuse morbidity and mortality data from New Zealand. Computerized files of all intentional injury fatalities among children 16 years of age and under for 1978 to 1987, and all hospital discharges for intentionally injured children 16 and under for 1988 were analyzed for evidence of physical and sexual abuse. Among the 92 fatalities, only 21 of 68 deaths due to physical and/or sexual abuse were so coded. In both the mortality and the morbidity data, there was an association between the diagnosis of child abuse and race.

Oliver, J.E. (1983). Dead children from problem families in NE Wiltshire. British Medical Journal, 286, 115–117.

Analysis of 147 families in Northeast Wiltshire, England, known to have suffered child neglect or abuse over two generations showed that in 560 children had been born in a 21-year period. Of these, 513 were known to have been neglected or assaulted or both; 41 had died. Detailed collated confidential information indicated that parental behavior towards the dead children, in particular those aged from 5 weeks to 1 year, had often caused or contributed to their deaths, including some claimed to be clear-cut cases of accident or illness.

Somander, L.K.H. & Rammer, L.M. (1991). Intra- and extrafamilial child homicide in Sweden 1971-1980. Child Abuse and Neglect, 15, 45–55.

Over the 10-year period studied, a total of 96 children under 15 years of age were killed in Sweden. This number constituted an average annual rate of 0.6 per 100,000 children. The violence, most frequently involving strangulation, shooting, and stabbing, was largely directed at young children. The pattern of child homicide was mainly characterized by intrafamilial violence, especially in connection with the suicide of a parent-perpetrator. Extrafamilial homicides were rare and only committed by male perpetrators. Cases of child abuse by a parent and cases of sexual abuse were infrequent.

Wilkey, I., Pearn, J., Petrie, G., & Nixon, J. (1982). Neonaticide, infanticide and child homicide. Medicine, Science, and the Law,22(1), 31–34.

A total population study of neonaticide, infanticide, and child homicide in Queensland, Australia is reported. Using case records, coroner records, and inquest files of every case of nonaccidental injury and child neglect, the authors have identified seven distinct syndromes of unlawful child killing. Analyses include age of victim, type and circumstances of death, and geographic location by year of death.

Type of Death

Bass, M., Kravath, R.E., & Glass, L. (1986). Death-scene investigation in sudden infant death. The New England Journal of Medicine, 315, 100–105.

Death-scene investigations were conducted in 26 consecutive cases in which a presumptive diagnosis of sudden infant death syndrome (SIDS) was made among infants who were brought to the emergency room at the Kings County Hospital Center in Brooklyn, NY, between October 1983 and January 1985. In six cases there was strong circumstantial evidence of accidental death. In 18 other cases, various possible causes of death other than SIDS were discovered. This study suggests that many sudden deaths of infants have a definable cause that can be revealed by careful investigation of the death scene and that the extremely high rate of SIDS reported in the population of low socioeconomic status served by this hospital center should be questioned.

Berger, D. (1979). Child abuse simulating "near-miss" sudden infant death syndrome. The Journal of Pediatrics, 95(4), 554–556.

Two examples of child abuse by suffocation presenting as near-miss sudden infant death syndrome (SIDS) demonstrate the difficulty in differentiating these diagnoses. In both cases the initial histories, presentations, physical examinations, and laboratory findings were compatible with either diagnosis. Social factors, cited as risk factors for child abuse but also common to SIDS, add to the difficulty of differential diagnosis. Careful examination of near-miss SIDS cases is seen as imperative.

Ludwig, S. & Warman, M. (1984). Shaken baby syndrome: A review of 20 cases. Annals of Emergency Medicine, 13(2), 104-107.

Twenty cases of shaken baby syndrome are reviewed to determine important signs, symptoms, physical findings, laboratory parameters, and prognosis.

Reece, R.M. (1993). Fatal child abuse and sudden infant death syndrome: A critical diagnostic decision. Pediatrics, 91(2), 423–429.

Distinguishing between an unexpected infant death due to sudden infant death syndrome (SIDS) and one due to fatal child abuse challenges pediatricians, family physicians, pathologists, and child protection agencies. All agree that the state of our knowledge in this area is incomplete and that ambiguity exists in some cases. Investigating infant deaths requires application of current knowledge, the resources necessary to conduct essential procedures, and the sensitivity and wisdom to perform the task without causing distress to innocent family members. These issues are discussed.

Perpetrator Characteristics

Archer, J. (1991). Human sociobiology: Basic concepts and limitations. Journal of Social Issues, 47(3), 11-26.

Principles underlying the sociobiological, or functional evolutionary, approach to behavior are outlined. Application of sociobiological principles to topics in Psychology, such as altruism, homicide, child abuse, and socialization, are outlined. Problems with the functional approach are identified, notably limitations to the assumption of the adaptiveness of behavior, and confusion of functional and causal explanations.

Bourget, D. & Bradford, J.M.W. (1990). Homicidal parents. Canadian Journal of Psychiatry, 35(3), 233–238.

In a retrospective study of 13 cases of parents who have killed their children, the relevant demographic and clinical data are reviewed. The diagnostic classification using the *DSM-III-R* is discussed in detail. A higher incidence of maternal perpetrators was found, and exposure to a variety of psychosocial stresses appears to have been a major factor. Similarly the suicidal history and behavior of the subjects is significant.

Daly, M. & Wilson, M. (1985). Child abuse and other risks of not living with both parents. Ethology and Sociobiology, 6, 197210.

This study was undertaken to quantify various risks to children as a function of the identity of the person(s) *in loco parentis*. The household circumstances of children in a midsized Canadian city were surveyed by telephone, and combined with information on child abuse victims, runaways, and juvenile offenders, to arrive at victimization rates according to age and household type. Both abuse and police apprehension were least likely for children living with two natural parents. Whereas abuse risk was significantly higher for children living with a stepparent than for those with a single parent, the reverse was true of the risk for apprehension for criminal offenses.

d'Orban, P.T. (1979). Women who kill their children. British Journal of Psychiatry, 134, 560-571.

During a 6-year period (1970–75), 89 women charged with the killing or attempted murder of their children were examined in a female remand prison. Six types of maternal filicide were distinguished: battering mothers (36), mentally ill mothers (24), neonaticides (11), retaliating mothers (9), women who killed unwanted children (8) and mercy killing (1). Types of filicide were compared on a number of social and psychiatric characteristics and on their offence patterns and court disposals.

Husain, A. & Anasseril, D. (1984). A comparative study of filicidal and abusive mothers. Canadian Journal of Psychiatry, 29(7), 596–598.

In this paper the authors report on a study of 8 filicidal and 52 abusive mothers referred to them by courts for pre-trial psychiatric evaluation. They found that there were significant differences between the two groups with regard to previous mental illness. They conclude that filicidal mothers are different from abusive mothers and that the risk of fatality as a complication of child abuse increases significantly when psychiatric illness is present in the mother.

Kaplan, M.F. (1988). A peer support group for women in prison for the death of a child. Journal of Offender Counseling, Services, and Rehabilitation, 13(1), 5–13.

A peer support group program for women in prison for the death of a child has helped the participants reduce their isolation, mourn their loss, identify their responsibility in the death and change destructive patterns of feelings and behavior. Follow up of women who have been paroled indicates their positive adjustment to the community.

Kaplun, D. & Reich, R. (1976). The murdered child and his killers. American Journal of Psychiatry, 133(7), 809-813.

The authors studied 112 cases of child homicide in New York City during 1968-1969 to identify contributing social and psychiatric factors and to determine the fate of the surviving siblings and the degree of involvement of the city's social agencies with the families. There was a pattern of long-term familial child maltreatment extending to the siblings and continuing after the murders. The victims were usually illegitimate preschoolers; the assailants, usually the mothers or their paramours, had backgrounds of assaultiveness and social deviance and killed in impulsive rage. Case illustrations and prevention guidelines are presented.

Korbin, J.E. (1986). Childhood histories of women imprisoned for fatal child maltreatment. Child Abuse and Neglect, 10, 331–338.

A history of childhood maltreatment is the most consistently reported characteristic of abusive parents. Retrospective research with nine women imprisoned for fatal child abuse revealed childhood histories of maltreatment. Detailed life histories indicated that early abuse had an impact on later abusive parenting. Childhood abuse was only one in a set of factors contributing to abusive parenting.

Korbin, J.E. (1987). Incarcerated mothers' perceptions and interpretations of their fatally maltreated children. Child Abuse and Neglect, 11, 397–407.

Fatally maltreated children are an elusive component in the complex interaction that has led to their premature deaths. Retrospective research with women imprisoned for fatal child maltreatment indicated recurring themes of maternal interpretations of their children as rejecting and developmentally abnormal, either advanced or delayed. Separations and difficulties during reunions were critical. The fatality was not a one-time event, but the exit point of a recurrent cycle of abusive interaction.

Korbin, J.E. (1989). Fatal maltreatment by mothers: A proposed framework. Child Abuse and Neglect, 13, 481-489.

This paper proposes a framework for understanding fatal maltreatment by mothers based on an in-depth study of incarcerated women. Despite its extreme outcome, fatal maltreatment is not homogeneous. While the specifics of each case varied, the circumstances leading to the fatality followed a similar progression. The framework is characterized by a recurrent pattern of abuse culminating in the fatality. All of the women had abused the deceased child prior to the fatality, and had provided warning signals to professionals and to members of their personal networks. Intervention approaches are also discussed.

Silverman, R.A. & Kennedy, L.W. (1988). Women who kill their children. Violence and victims, 3(2), 113–127.

This paper examines in what way homicides in which women have killed their children are distinctive from spousal homicides, specifically in terms of the characteristics of the offenders and victims, the circumstances of the murders, and the motivations attached to the offenders.

Weisheit, R.A. (1986). When mothers kill their children. The Social Sciences Journal, 23(4), 439-448.

Of 460 female homicide offenders admitted to a state prison for women during 1940–1983, 39 were institutionalized for killing their children. Among these offenders, several interesting changes over time were noted. Women in the earlier time periods were more likely to be married and white. The authors note also that women who kill their children are becoming more similar over time to other types of female homicide offenders.

Community and Social Factors

Daniel, J.H., Hampton, R.L., & Newberger, E.H. (1983). Child abuse and accidents in black families: A controlled comparative study. American Journal of Orthopsychiatry, 53, 645-653.

This paper presents a comparison of risk indicators for accidents and abuse among the African Ameican families that participated in a larger study of pediatric social illnesses. Socioeconomic factors that play a significant role in imposing undue stress upon many families are identified, and implications for prevention and for practice are offered.

Gelles, R.J. (1989). Child abuse and violence in single-parent families: Parent absence and economic deprivation. American Journal of Orthopsychiatry, 59, 492–501.

A national survey of 6,000 households found single parents to be more likely to use abusive forms of violence toward their children than are parents in dual-caretaker households. Abusive violence appears to be a function of poverty in mother-only homes but unrelated to income among single fathers.

Gelles, R.J. (1992). Poverty and violence toward children. American Behavioral Scientist, 35, 258–274.

This article examines the relationship between poverty and violence toward children. To avoid the labeling bias inherent in clinical and official records of child maltreatment, the author draws on data collected from two national family violence surveys.

Garbarino, J. (1977a). The price of privacy in the social dynamics of child abuse. Child Welfare, 56, 565–575.

Under certain conditions, family isolation serves as the catalytic agent for child abuse. Privacy that excludes intrusive kinship and neighborhood networks can be a danger to children.

Garbarino, J. (1977b). The human ecology of child maltreatment: A conceptual model for research. Journal of Marriage and the Family, 721–735.

This paper seeks to place the phenomenon of child maltreatment in the perspective of family development. It focuses on necessary and sufficient conditions and the research implications of an ecological perspective. Concepts discussed include maltreatment as a consequence of stressful role transition, the role of cultural support, and a model of child maltreatment as a problem of family asynchrony.

Garbarino, J. & Kostelny, K. (1992). Child maltreatment as a community problem. Child Abuse & Neglect, 16, 455-464.

The study involves 77 community areas within the Chicago, IL, metropolitan area. Child maltreatment rates are related to indicators of socioeconomic and demographic well-being for these neighborhoods and for the subunits within them. The results reveal a strong influence of socioeconomic and demographic factors on child maltreatment rates. High-risk areas are characterized by social disorganization and lack of social coherence in contrast to the low-risk areas which evidence a stronger social fabric. These effects extend to differences in child abuse fatalities.

Gaudin, J.M. & Polansky, N.A. (1986). Social distancing of the neglectful family: Sex, race, and social class influences. Children and Youth Services Review, 8, 1–12.

A social distance questionnaire was constructed and administered to 232 urban residents. Scalogram analysis yielded two scales of social distancing behavior applicable at the neighborhood level. Males and working class respondents averaged greater distancing than females and members of the middle class among both African Americans and whites. Implications are offered for social network interventions to prevent neglect.

Gaudin, J.M., Polansky, N.A., Kilpatrick, A.C., & Shilton, P. (1993). Loneliness, depression, stress, and social supports in neglectful families. American Journal of Orthopsychiatry, 63, 597–605.

Comparisons of neglectful with nonneglectful low-socioemnomic status parents revealed that the neglectful parents reported more life stresses, greater depression and loneliness, and weaker informal social supports. In the neglectful families, loneliness was positively associated with life stresses and negatively associated with network supports, but not with caseworker-assessed social isolation.

Hampton, R.L. (1987). Race, class, and child maltreatment. Journal of Comparative Family Studies, 18, 113–126.

The goal of this study is to determine whether and where ethnic differences may exist within a sample of maltreated children with respect to the nature, type, and severity of maltreatment or factors associated with maltreatment. Using data from the NIS study, comparisons are made among African American and Hispanic maltreatment cases.

Hampton, R.L., & Newberger, E.H. (1985). Child abuse incidence and reporting by hospitals: Significance of severity, class, and race. American Journal of Public Health, 75, 56–60.

Estimates from the National Study of the Incidence and Severity of Child Abuse and Neglect suggest that hospitals recognized over 77,000 cases of child abuse between May 3 1979, and April 30, 1980. Compared to the other agencies in the sample, hospitals identified children who were younger, African American, lived in urban areas, and had more serious injuries. Hospitals failed to report to child protection agencies almost half of the cases that met the study's definition of abuse. Disproportionate numbers of unreported cases were victims of emotional abuse and came from families of higher income. Their mothers were more often White and more often alleged to be responsible for the injuries.

Miller, J.L., & Whittaker, J.K. (1988). Social services and social support: Blended programs for families at risk of child maltreatment. Child Welfare, 67, 161–174.

Social support, increasingly put forth as fundamental in helping multiproblem families to avoid placement, is a complex construct not easy to define and far more difficult to carry out conceptually and practically. This article describes four family support programs that illustrate certain common denominators for implementation.

Nixon, J., Pearn, J., Wilkey, I., & Petrie, G. (1981). Social class and violent child death: An analysis of fatal nonaccidental injury, murder, and fatal child neglect. Child Abuse and Neglect, 5, 111–116.

A total population study to analyze socioeconomic status (SES) concomitants of violent and nonaccidental deaths involving children in Queensland, Australia is reported. All children dying of nonaccidental injuries, neglect, and murder were included. Of the 43 children in the study, 58 percent were girls. All of the children who died as a result of nonaccidental injury were from lower SES groups.

Polansky, N.A., Ammons, P.W., & Gaudin, J.M. (1985). Loneliness and isolation in child neglect. Social Casework, 38-47.

This investigation of 156 African American and white low-income families from rural Georgia contrasted neglectful with control families. The isolation and loneliness of neglectful mothers was confirmed, although their neighborhoods were no less supportive than those of non-neglectful mothers.

Seagull, E.A. (1987). Social support and child maltreatment: A review of the evidence. Child Abuse & Neglect, 11, 41–52.

This review critically examines what is known regarding the relationship between child maltreatment and parental isolation from informal helping networks. The author argues that the existing research is fraught with both conceptual and methodological problems and that little conclusive evidence exists.

Telleen, S. (1990). Parental beliefs and help seeking in mothers' use of a community-based family support program. Journal of Community Psychology, 18, 264–276.

The purpose of the study was to examine help seeking from family support programs within an attributional framework. Mothers participating in a community-based family support program were compared to mothers not using a family support program in a Midwestern town with a manufacturing economic base, high unemployment, and an increasing rate of confirmed child abuse. Though the mothers seeking help were not depressed, they believed that they lacked competence and expressed more need for social support in parenting than did the comparison mothers not using the program.

Vondra, J.I. (1990). The community context of child abuse and neglect. Marriage & Family Review, 15, 19–38.

Focusing on community-level analysis and using an ecological perspective, this article reviews both the empirical literature and the incidence data on risk factors that characterize families involved in and circumstances surrounding child maltreatment. The discussion of risk factors focuses on parents and stepparents who demonstrate inadequacies of caregiving that meet common definitions of abuse and neglect.

Zuravin, S.J. (1989). The ecology of child abuse and neglect: Review of the Literature and presentation of data. Violence and Victims, 4, 101–120.

This report assesses current knowledge about the ecological determinants of child maltreatment and presents data from an aggregate study of covariation between seven community characteristics and maltreatment rates. Nothing is known about the ecology of sexual abuse, and studies of physical abuse and neglect have done little more than demonstrate covariation between reported incidence and neighborhood population and housing characteristics.

Prevention

Donnelly, A.H.C. (1991). What we have learned about prevention: What we should do about it. Child Abuse and Neglect, 15, Supp.1, 99-106.

This paper looks generally at the focus on prevention of child abuse efforts throughout the world. It reviews what has transpired in the last decade with regard to advocacy and public policy and outlines the challenges that lie ahead in years to come.

Honig, A.S. & Pfannenstiel, A.E. (1991). Difficulties in reaching low-income new fathers: Issues and cases. Early Child Development and Care, 77, 115–125.

Of a group of 67 low-income first-time fathers-to-be, half were randomly assigned during the second trimester of pregnancy to participate in an intervention program designed to acquaint fathers with information, insights, and clinically appropriate techniques in responsive care for infants. Difficulties in recruitment of fathers were caused by lack of commitment of father to partner or infant, by suspicion of a project about babies, by father drug and alcohol abuse, illiteracy, and personality problems. Transportation to the clinic and oral presentation helped ensure participation. Early identification of fathers, skill and persistence of the intervener, and continuity of caring are identified as prognosticators of success in reaching low-income fathers-to-be.

Kelley, S.J. (1992). Parenting stress and child maltreatment in drug-exposed children. Child Abuse and Neglect, 16, 317–328.

This study was conducted to examine the relationship between prenatal exposure to drugs and parenting stress and child maltreatment. The sample was comprised of 48 subjects including 24 drug-exposed children and a comparison group of 24 non-drug-exposed children matched on age, race, gender, and socioeconomic status. As predicted, mothers who used drugs during pregnancy reported higher levels of stress than foster mothers and comparison mothers on total parenting stress, child related stress, and parent related stress. Biological mothers and foster mothers of drug-exposed infants scored higher than comparisons on child-related stress, most notably in the areas of hyperactivity, distractibility, and adaptability. A strong association was found between maternal use of drugs and child maltreatment serious enough to necessitate removal of children by child protective services. Implications for intervention are discussed.

Maney, A.C. & Kedem, B. (1982). A binary time-series analysis of domestic child homicide—on monitoring critical, rare criteria of system performance. Evaluation Review, 6(3), 393–402.

This article seeks to evaluate the significance of variations in the number of domestic child homicides and to do this in a way that facilitates the search for causes in a community's child protection system. Domestic child homicide is but one of many possible outcome measures, one seldom used and almost never related to other events in the system designed to protect children from such catastrophe. The study proposes a novel solution to the statistical problems associated with the evaluation of rare events.

Schmitt, B.D. (1987). Seven deadly sins of childhood: Advising parents about difficult developmental phases. Child Abuse and Neglect, 11, 421-432.

Seven of the more difficult developmental phases for any parent to deal with are colic, awakening at night, separation anxiety, normal exploratory behavior, normal negativism, normal poor appetite, and toilet training resistance. For the child living in a high-risk family, these innocent acts can trigger dangerous or even deadly abuse. The two behaviors most commonly associated with fatal abuse are colic and toilet training. When a child is recognized to be entering a provocative phase, professionals should be prepared to advise the parents on practical alternatives to a physical response.

Tertinger, D.A., Greene, B.F., & Lutzker, J.R. (1984). Home safety: Development and validation of one component of an ecobehavioral treatment program for abused and neglected children. Journal of Applied Behavior Analysis, 17, 159–174.

In this study, the authors describe the development of a Home Accident Prevention Inventory (HAPI), which was validated and used to assess hazards in homes of several families under state protective service for child abuse and neglect.The HAPI included five categories of hazards: fire and electrical, mechanical-suffocation, ingested object suffocation, firearms, and solid/liquid poisons.

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Sellers, L.A. (1993). Child Homicide: Child Abuse Fatalities in Mississippi. Hattiesburg, MS: University of Southern Mississippi.

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South Carolina

South Carolina Department of Social Services. (1993). 1989 through 1991: Fatal Child Abuse and Neglect in South Carolina. Columbia, SC: South Carolina Department of Social Services.

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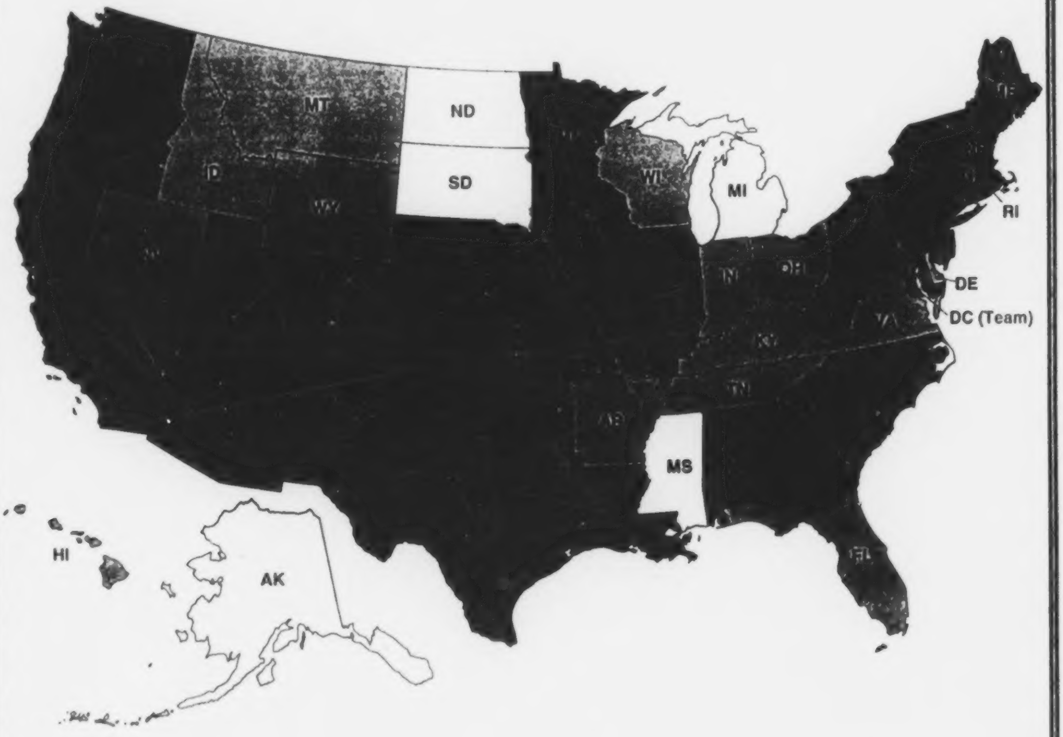
Robinson, D.H. & Stevens, G.M. (1992). Child Abuse and Neglect Fatalities: Federal and State Issues and Responses. Washington, DC: Congressional Research Service, The Library of Congress.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect. Child Maltreatment 1992: Reports From the States to the National Center on Child Abuse and Neglect. Washington, DC: U.S. Government Printing Office, 1994.

Map of Child Death Review Teams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DC (Team)
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MULTIAGENCY CHILD DEATH REVIEW TEAMS*

(Ontario Canada has a team*)

***TEAMS INCLUDE:**

- Criminal Justice, Social Services, Health
- Multiagency, Systematic, Peer Review
- Case Selection From Coroner or Health

CHILD DEATH REVIEW TEAMS

■ State Team*

▨ Local Team* Only

☐ Formal Planning

Survey - Michael Durfee M.D. - March 20, 1995

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International Contacts for Multiagency Child Death Review Activities

Australia

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NSW 2145
Westmead, Australia

Canada

James Young
Chief Coroner
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Community Services Division
Department of Health
Wellington House
133-155 Waterloo Road
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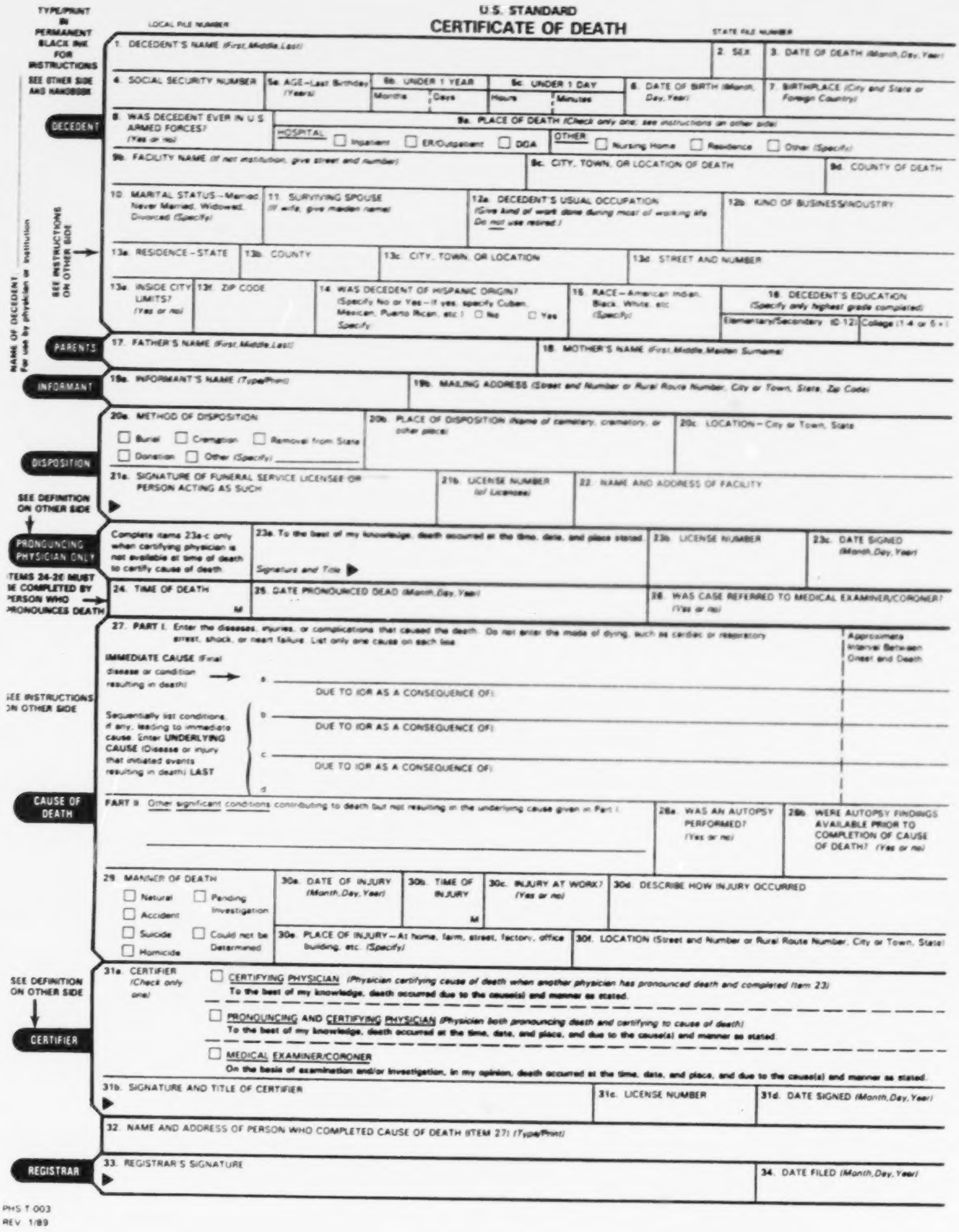
(071) 972-4519



TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK

U.S. STANDARD

CERTIFICATE OF DEATH

LOCAL FILE NUMBER

STATE FILE NUMBER

DECEDENT

1. DECEDENT'S NAME *(First, Middle, Last)*
2. SEX
3. DATE OF DEATH *(Month, Day, Year)*
4. SOCIAL SECURITY NUMBER

5a. AGE—Last Birthday *(Years)*

5b. UNDER 1 YEAR: Months, Days

5c. UNDER 1 DAY: Hours, Minutes

6. DATE OF BIRTH *(Month, Day, Year)*
7. BIRTHPLACE *(City and State or Foreign Country)*
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? *(Yes or no)*

9a. PLACE OF DEATH *(Check only one; see instructions on other side)*

HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA

OTHER: ☐ Nursing Home ☐ Residence ☐ Other *(Specify)*

9b. FACILITY NAME *(If not institution, give street and number)*

9c. CITY, TOWN, OR LOCATION OF DEATH

9d. COUNTY OF DEATH

10. MARITAL STATUS—Married, Never Married, Widowed, Divorced *(Specify)*
11. SURVIVING SPOUSE *(If wife, give maiden name)*

12a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired.)*

12b. KIND OF BUSINESS/INDUSTRY

13a. RESIDENCE—STATE

13b. COUNTY

13c. CITY, TOWN, OR LOCATION

13d. STREET AND NUMBER

13e. INSIDE CITY LIMITS? *(Yes or no)*

13f. ZIP CODE

14. WAS DECEDENT OF HISPANIC ORIGIN? *(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)* ☐ No ☐ Yes Specify
15. RACE—American Indian, Black, White, etc. *(Specify)*
16. DECEDENT'S EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12) College (1-4 or 5+)

NAME OF DECEDENT ______ For use by physician or institution

SEE INSTRUCTIONS ON OTHER SIDE

PARENTS

17. FATHER'S NAME *(First, Middle, Last)*
18. MOTHER'S NAME *(First, Middle, Maiden Surname)*

INFORMANT

19a. INFORMANT'S NAME *(Type/Print)*

19b. MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DISPOSITION

20a. METHOD OF DISPOSITION

☐ Burial ☐ Cremation ☐ Removal from State

☐ Donation ☐ Other *(Specify)* ______

20b. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)*

20c. LOCATION—City or Town, State

21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶

21b. LICENSE NUMBER *(of Licensee)*

22. NAME AND ADDRESS OF FACILITY

SEE DEFINITION ON OTHER SIDE

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death.

23a. To the best of my knowledge, death occurred at the time, date, and place stated. *Signature and Title* ▶

23b. LICENSE NUMBER

23c. DATE SIGNED *(Month, Day, Year)*

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH

24. TIME OF DEATH M
25. DATE PRONOUNCED DEAD *(Month, Day, Year)*
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? *(Yes or no)*

CAUSE OF DEATH

SEE INSTRUCTIONS ON OTHER SIDE

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ______

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**

b. ______

DUE TO (OR AS A CONSEQUENCE OF):

c. ______

DUE TO (OR AS A CONSEQUENCE OF):

d. ______

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? *(Yes or no)*

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? *(Yes or no)*

29. MANNER OF DEATH

☐ Natural ☐ Pending Investigation

☐ Accident

☐ Suicide ☐ Could not be Determined

☐ Homicide

30a. DATE OF INJURY *(Month, Day, Year)*

30b. TIME OF INJURY M

30c. INJURY AT WORK? *(Yes or no)*

30d. DESCRIBE HOW INJURY OCCURRED

30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. *(Specify)*

30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

CERTIFIER

SEE DEFINITION ON OTHER SIDE

31a. CERTIFIER *(Check only one)*

☐ CERTIFYING PHYSICIAN *(Physician certifying cause of death when another physician has pronounced death and completed Item 23)*
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN *(Physician both pronouncing death and certifying to cause of death)*
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

31b. SIGNATURE AND TITLE OF CERTIFIER ▶

31c. LICENSE NUMBER

31d. DATE SIGNED *(Month, Day, Year)*

32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) *(Type/Print)*

REGISTRAR

33. REGISTRAR'S SIGNATURE ▶
34. DATE FILED *(Month, Day, Year)*

PHS-T-003
REV. 1/89

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INSTRUCTIONS FOR SELECTED ITEMS

Item 9. – Place of Death
If the death was pronounced in a hospital, check the box indicating the decedent's status at the institution (inpatient, emergency room/outpatient, or dead on arrival (DOA)). If death was pronounced elsewhere, check the box indicating whether pronouncement occurred at a nursing home, residence, or other location. If other is checked, specify where death was legally pronounced, such as a physician's office, the place where the accident occurred, or at work.

Items 13 a-f. – Residence of Decedent
Residence of the decedent is the place where he or she actually resided. This is not necessarily the same as "home State," or "legal residence." Never enter a temporary residence such as one used during a visit, business trip, or a vacation. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and should be considered as the place of residence.

If a decedent had been living in a facility where an individual usually resides for a long period of time, such as a group home, mental institution, nursing home, penitentiary, or hospital for the chronically ill, report the location of that facility in items 13a through 13f.

If the decedent was an infant who never resided at home, the place of residence is that of the parent(s) or legal guardian. Do not use an acute care hospital's location as the place of residence for any infant.

Items 23 and 31. – Medical Certification
The PRONOUNCING PHYSICIAN is the person who determines that the decedent is legally dead but who was not in charge of the patient's care for the illness or condition which resulted in death. Items 23a through 23c are to be completed only when the physician responsible for completing the medical certification of cause of death (item 27) is not available at time of death to certify cause of death. The pronouncing physician is responsible for completing only items 23 through 26.

The CERTIFYING PHYSICIAN is the person who determines the cause of death (item 27). This box should be checked only in those cases when the person who is completing the medical certification of cause of death is not the person who pronounced death (item 23). The certifying physician is responsible for completing items 27 through 32.

The PRONOUNCING AND CERTIFYING PHYSICIAN box should be checked when the same person is responsible for completing items 24 through 32, that is, when the same physician has both pronounced death and certified the cause of death. If this box is checked, items 23a through 23c should be left blank.

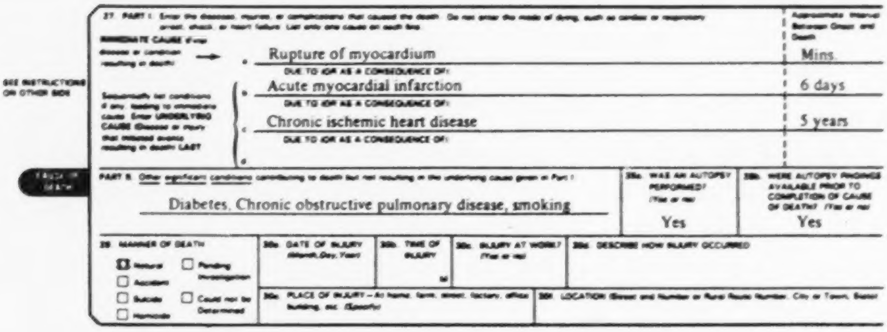
The MEDICAL EXAMINER/CORONER box should be checked when investigation is required by the Post Mortem Examination Act and the cause of death is completed by a medical examiner or coroner. The Medical Examiner/Coroner is responsible for completing items 24 through 32.

Item 27. – Cause of Death
The cause of death means the disease, abnormality, injury, or poisoning that caused the death, not the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.

In Part I, the immediate cause of death is reported on line (a). Antecedent conditions, if any, which gave rise to the cause are reported on lines (b), (c), and (d). The underlying cause, should be reported on the last line used in Part I. No entry is necessary on lines (b), (c), and (d) if the immediate cause of death on line (a) describes completely the train of events. ONLY ONE CAUSE SHOULD BE ENTERED ON A LINE. Additional lines may be added if necessary. Provide the best estimate of the interval between the onset of each condition and death. Do not leave the interval blank; if unknown, so specify.

In Part II, enter other important diseases or conditions that may have contributed to death but did not result in the underlying cause of death given in Part I.

See examples below.



27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

SEE INSTRUCTIONS ON OTHER SIDE

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Rupture of myocardium — Mins.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute myocardial infarction — 6 days
DUE TO (OR AS A CONSEQUENCE OF):
c. Chronic ischemic heart disease — 5 years
DUE TO (OR AS A CONSEQUENCE OF):
d.

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes, Chronic obstructive pulmonary disease, smoking

28a. WAS AN AUTOPSY PERFORMED? (Yes or no) Yes

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) Yes

29. MANNER OF DEATH
☒ Natural ☐ Pending Investigation
☐ Accident
☐ Suicide ☐ Could not be Determined
☐ Homicide

30a. DATE OF INJURY (Month, Day, Year)

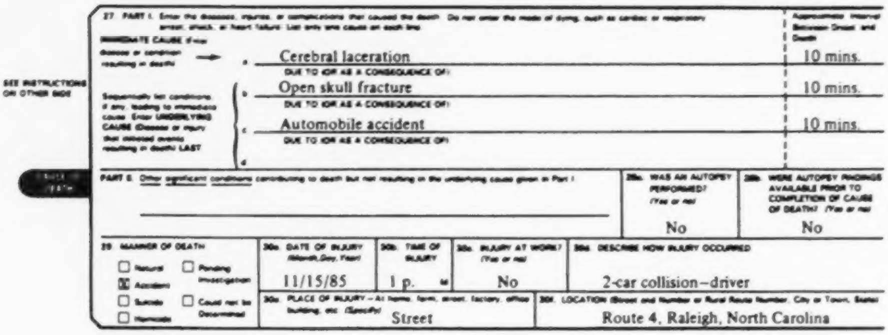
30b. TIME OF INJURY M

30c. INJURY AT WORK? (Yes or no)

30d. DESCRIBE HOW INJURY OCCURRED

30e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify)

30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)



27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

SEE INSTRUCTIONS ON OTHER SIDE

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral laceration — 10 mins.
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Open skull fracture — 10 mins.
DUE TO (OR AS A CONSEQUENCE OF):
c. Automobile accident — 10 mins.
DUE TO (OR AS A CONSEQUENCE OF):
d.

CAUSE OF DEATH

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? (Yes or no) No

28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (Yes or no) No

29. MANNER OF DEATH
☐ Natural ☐ Pending Investigation
☒ Accident
☐ Suicide ☐ Could not be Determined
☐ Homicide

30a. DATE OF INJURY (Month, Day, Year) 11/15/85

30b. TIME OF INJURY 1 p. M

30c. INJURY AT WORK? (Yes or no) No

30d. DESCRIBE HOW INJURY OCCURRED 2-car collision–driver

30e. PLACE OF INJURY – At home, farm, street, factory, office building, etc. (Specify) Street

30f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Route 4, Raleigh, North Carolina

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